2002

A Status Report

of the
Auditor General of Canada
to the House of Commons

SEPTEMBER

The September 2002 Report of the Auditor General of Canada comprises five chapters, and a Message from the Auditor General.

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AUDITOR GENERAL OF CANADA

CANADA

VÉRIFICATEUR GÉNÉRAL DU CANADA

To the Honourable Speaker of the House of Commons:

I have the honour to transmit herewith my second Report of 2002 to the House of Commons, which is to be tabled in the House in accordance with the provisions of subsection 7(5) of the *Auditor General Act*.

Sheila Fraser

Sheila Fraser, FCA
Auditor General of Canada

OTTAWA, 26 September 2002

Table of Contents

A Message from the Auditor General of Canada

Chapter 1 Human Resources Development Canada—The Integrity of the Social Insurance Number

Chapter 2 Health Canada—National Health Surveillance

Chapter 3 Health Canada—Federal Support of Health Care Delivery

Chapter 4 National Defence—NATO Flying Training in Canada

Chapter 5 Industry Canada—Management of the Canada Small Business Financing Program

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Sheila Fraser, FCA
Auditor General of Canada

A Message from the Auditor General of Canada

I am pleased to present this first Status Report to the House of Commons. It reports on our audits of the steps that federal government departments and agencies have taken to implement some of the recommendations we have made within the past five years. Taking into account Parliament's response to this report, I intend to present a status report to the House of Commons each year, with the next one in the spring of 2003.

A new approach to following up on past reports to Parliament

Although follow-up on our previous recommendations has been part of our regular work for many years, this year we have taken a new approach to the way we carry out our follow-up. This Status Report is a new approach to reporting on that work.

What distinguishes the five chapters in this report from our previous follow-up work is the way we selected the issues, the scope and depth of our review, and the assurance our findings provide.

From routinely reporting on all previous recommendations two years after the original audit, with these new reports we move to a focus on the issues that are most significant—those that are systemic, timely, still relevant, carry higher risk, and in our view are of interest to parliamentarians. In some cases, we extended our work to include new issues that are relevant to the original audit work.

Our previous approach relied on status reports from departments on action they had taken to address our recommendations; we would evaluate those reports to assess whether they seemed plausible. In some cases we would do additional work where we believed it was warranted. The chapters in this report present instead the results of conventional audits, meeting all our normal standards of evidence and quality management.

We also decided to change the way we report our follow-up work. Previously, we included follow-up work in reports with chapters devoted to new audit work. We realized that the new recommendations overshadowed the impact our follow-up work had on both the departments' priorities for action and the visibility of the issues. The lack of visibility tended to conceal successful corrective action as well as failures to act. Now, the yearly Status Report will be devoted entirely to our follow-up work and will become one of the four reports I provide each year to the House of Commons.

Part of a continuing evolution of service to Parliament

Our new and enhanced approach to following up on previous recommendations is consistent with the evolution of this Office's efforts to provide Parliament with the information it needs to determine whether or not Canadians are getting value for money.

It so happens that the publication of this report coincides with the 25th anniversary of the *Auditor General Act* of 1977. That legislation formally broadened the Auditor General's mandate to include reporting on whether government policies are being implemented economically, efficiently, and with adequate means for judging their effectiveness. The Act marked the birth of value-for-money auditing in Canada—that is, examining whether Canadians are getting their money's worth for their tax dollars.

Legislative auditing has changed a great deal since the appointment of the first Auditor General of Canada in 1878. As government has evolved and become more complex, the kinds of information Parliament needs to hold the government to account have also changed. Accordingly, my predecessors adapted their approach to auditing, with Parliament's encouragement, to provide the needed information.

The roots of value-for-money auditing in Canada date back more than 50 years to the *Financial Administration Act* of 1951, which empowered the Auditor General to report to Parliament "any other case that he considers should be brought to the attention of the House." The fifth Auditor General, Watson Sellars, started in 1958 to report what he called "unproductive expenditures" of government funds. His successor, Maxwell Henderson, reported three such examples in his first report of 1960, and asked Parliament whether or not he should continue. The Public Accounts Committee said yes.

Value-for-money auditing was formally launched during James Macdonell's term as Auditor General, when the *Auditor General Act* of 1977 expanded his mandate to include reporting on whether government policies were being implemented economically and efficiently and whether departments had in place reliable, up-to-date measures of effectiveness. Macdonell was the first Auditor General to make recommendations to departments on how to remedy problems rather than simply enumerating them for Parliament and was the first to publish departments' reactions to findings and recommendations in his reports. Both innovations were carried on by his successors and are incorporated in the new Status Report.

Our reports do lead to change

Since 1977, the Auditor General has submitted to the House of Commons hundreds of value-for-money chapters with thousands of recommendations. Public interest peaks immediately following tabling, when the news is fresh and the media are full of stories that shock, amuse, or merely perplex. Like my predecessors, I note that public attention to the issues has not always corresponded with their relative significance.

Members of Parliament focus most visibly on the report during Question Period immediately following tabling. A less visible but more thorough examination of the issues we raise occurs in the following months, when various committees of the House and the Senate, and particularly the Standing Committee on Public Accounts, consider our reports in detail and invite senior officials from the departments concerned to answer committee

members' questions. Following these discussions, the Public Accounts Committee makes its own report to the House with recommendations to the government. Other standing committees of the House of Commons or the Senate also review our reports and issue their own.

The Public Accounts Committee's consideration of issues raised in our reports and its questioning of senior officials of departments about their actions to address them are not always noticed by the public. Though the Committee's meetings are usually open to the public, few journalists attend and there is little news coverage of the hearings, the Committee's reports, or the government's responses. As a result, the public may believe that after the initial impact of our reports, departments take no action.

However, that impression is not supported by our annual compilation of the status of recommendations we have made over the five preceding years and our assessment of departments' progress. We collect information on all recommendations for five years after an audit, and we track in a database what departments say they have done to address them. In our annual performance report, we publish the percentage of our recommendations that have been implemented satisfactorily. For the period 1996–2000, for example, our database shows that departments reported having completed the recommended action on a quarter of the recommendations we made and having made satisfactory progress on half of them.

At first, I was surprised to find that the satisfactory level of implementation indicated in our database was not matched by our evaluations of departments' progress in the five chapters of this Status Report—which are the results of our new approach to follow-up, one that is more rigorous and more intensive than the assessments in our database.

I can think of at least two reasons for this.

First, audit recommendations by their nature are intended to correct problems. Follow-up on past recommendations, then, means looking at areas where there were problems—some of which will need more time and resources to resolve. Since our new Status Report focusses on the issues that we believe need to be brought once again to Parliament's attention—the most complex and most significant issues that pose the greatest risk—it could be expected that our findings would be less than satisfactory.

In addition, some of the problems touched on in these five chapters are long-standing, extremely complex issues such as federal support for health care. In such areas, the federal government is not the only player, and we can comment only on how it carries out its share of the responsibility. However, in the following chapters the unsatisfactory progress we report indicates that the government needs to step up its efforts to correct problems that we have identified and that Parliament—and in most cases the departments themselves—agree must be addressed.

Listening to parliamentarians

Members of Parliament, particularly members of the Standing Committee on Public Accounts, have told us they want a more thorough follow-up of departments' progress in implementing our recommendations on key issues. Together, this Status Report and our annual monitoring of action on all our recommendations provide an overview of the government's progress in addressing problems identified by our audits.

I hope parliamentarians find that this new report provides the information they need to hold the government accountable and is a fitting way to mark the 25th anniversary of the *Auditor General Act* and the introduction of value-for-money auditing.

Sheila Fraser

Sheila Fraser, FCA

The audit work reported in this chapter was conducted in accordance with the legislative mandate, policies, and practices of the Office of the Auditor General of Canada. These policies and practices embrace the standards recommended by the Canadian Institute of Chartered Accountants.

Table of Contents

Key Message 1

Introduction 3

What is the Social Insurance Number? 3
Who is involved in administering the SIN? 3
Why is the integrity of the SIN important? 3
What we found in 1998 6
What has happened since 1998? 7
Focus of the audit 8

Observations and Recommendations 8

Role and importance of the SIN 8
Use of the SIN outside the federal government 8
Problems with the use of the SIN 9

Integrity of the issuing process 10
Applying for a SIN 10
SINs are issued without proper control 11
Staff lack adequate training, tools, and information 13
Inadequate control over SINs issued to applicants who are not Canadians or permanent residents 13

Integrity of the Social Insurance Register 16
Action taken to date 16
Information in the Register can be improved further 17
Dormant file review 18
Problems with information integrity persist 18
HRDC needs to better report on its improvements to the Register 19

Investigating fraud 21
A risk-based approach to investigation and control is needed 21
Investigators lack structured training and adequate tools 22

Conclusion 22

About the Audit 24

Human Resources Development Canada
The Integrity of the Social Insurance Number

Assistant Auditor General: Maria Barrados
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Key Message

1.1 Human Resources Development Canada (HRDC) has been slow to address many of the observations and recommendations arising from our 1998 audit of the management of the Social Insurance Number (SIN). In 2000 we reported that some improvements had been made in SIN records and the number of SIN-related fraud investigations had increased. In 2002 we returned, expecting to find that the problems reported in 1998 would have been largely resolved. Instead, we found that progress on some key issues has been limited. The continuing weakness in the issuing of SINs leads us to conclude that HRDC has not done enough to safeguard and strengthen the integrity of the SIN.

ORIGINAL ISSUES	PROGRESS	RATING*
1.2 The SIN had become a de facto national identifier, contrary to the government's intent. We encouraged the government to consider using planned privacy legislation to address concerns about the use of SIN outside the federal government.	The government reaffirmed its policy that the SIN was only an account number for authorized federal programs. To help protect personal information (including the SIN) outside the federal government, it is implementing the *Personal Information Protection and Electronic Documents Act*. HRDC has examined the use of the SIN in the private sector and has made efforts to raise public awareness of how the SIN should be used.	SATISFACTORY PROGRESS
1.3 HRDC needed to strengthen its process for issuing a SIN. It also needed to address the risks associated with SINs that do not expire and are issued to people such as visitors to Canada, who often need them only temporarily (900 series).	HRDC has made little change since 1998 in the way it issues SINs—regular ones or 900-series. In our view, the policies and practices of the Department do not meet the intent of the *Employment Insurance Act* and Regulations because it is not doing enough to identify SIN applicants properly. The Department has been providing better work tools to staff, albeit slowly. It recently completed a study of the way it issues SINs, as a basis for strengthening the integrity of the process.	LIMITED PROGRESS
1.4 HRDC needed to bring the reliability and completeness of its database of SIN records to an appropriate level.	Millions of SIN records have been cross-checked with other HRDC programs, although millions more will not be checked. The number of usable SINs for people over 20 years old exceeds the Statistics Canada Census figure by 5 million. HRDC believes there is little risk that 2.6 million of these SINs will be used as they have been dormant for some time. It recently started investigating activity on dormant SIN records. These SINs can still be used as a first step in accessing other federal programs.	LIMITED PROGRESS
1.5 HRDC needed to strengthen its approach to fraud investigations involving the SIN.	HRDC has increased the number of investigations but they are not guided by a comprehensive review of where the risks lie in issuing SINs. However, the Department has started providing better tools and training to its staff.	LIMITED PROGRESS

*Possible ratings are completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Audit for an explanation of the ratings.)

Human Resources Development Canada has responded. HRDC agrees with our recommendations and has committed itself to specific actions. HRDC will seek authority to cancel any SINs that have not been used in five years. It will also seek authority to place expiry dates on the SIN cards of people who are neither Canadian citizens nor permanent residents and will no longer accept photocopies of identity documents as proof of identity.

The Treasury Board Secretariat has responded. The Secretariat agrees with the recommendation we addressed to it.

Introduction

1.6 In 1998 we audited the management of the Social Insurance Number (SIN). We reported several problems in the way it was managed. We conducted a follow-up in 2000. Based on more recent audit work, this chapter provides a status report on the government's efforts to improve the integrity of the SIN.

What is the Social Insurance Number?

1.7 The Social Insurance Number was created in 1964 as a file identifier for the Canada Pension Plan, Quebec Pension Plan, and employment insurance (then unemployment insurance) programs. Under the current *Employment Insurance Act*, the Canada Employment Insurance Commission assigns "a number that is suitable for use as a file number or account number or for data processing purposes and the number so assigned...is the person's Social Insurance Number...." The SIN is a unique, nine-digit number assigned to each individual, and a person legitimately has only one number at a time.

1.8 The government's current policy views the SIN as a file identifier or account number for specifically authorized activities (Exhibit 1.1). The *Employment Insurance Act* and Regulations require that a SIN be issued only after an applicant's identity and citizenship status have been determined.

Who is involved in administering the SIN?

1.9 The Canada Employment Insurance Commission is named in the Act and Regulations as the body responsible for SIN administration. On behalf of the Commission, Human Resources Development Canada (HRDC) issues SINs and maintains the Social Insurance Register, which holds all relevant information on SIN applicants. The Treasury Board is responsible for the SIN policy, and the Treasury Board Secretariat is responsible for developing guidelines that govern how federal departments collect and use the SIN. The Canada Customs and Revenue Agency uses the SIN in administering the *Income Tax Act*. The Office of the Privacy Commissioner of Canada monitors federal organizations for their compliance with the *Privacy Act*, which governs the protection of personal information, including the SIN. For example, departments are required to inform the Privacy Commissioner of any significant changes to existing uses of personal information, specifically any new uses or disclosures.

1.10 In 2001–02, HRDC spent about $16.7 million on SIN administration and collected close to $2 million from people applying for replacement SIN cards. It issued a total of 1.2 million new cards and replacements.

Why is the integrity of the SIN important?

1.11 **The SIN is needed to access federal programs.** Several of the federal government's largest programs use the Social Insurance Number. In 2000–01 the SIN was the key account number on about three million applications for Employment Insurance benefits that totalled $9.5 billion and Canada Pension

Plan and Old Age Security benefits that totalled $43.7 billion. Applicants for benefits under these programs need a SIN. In 1998 we reported that by using the SIN, various programs had been able to avoid or recover overpayments and improve administrative efficiency, thereby achieving significant savings.

1.12 **Widespread use of the SIN outside the federal government.** Use of the SIN in the private sector began when the government made it a personal identifier for income tax, in 1967. Since then, the *Income Tax Act* has been amended several times to require that various public agencies collect a person's SIN in their transactions and to ask the same of private sector organizations, such as insurance companies and financial institutions. Various

Exhibit 1.1 Uses of the SIN in the public and private sectors

Public sector	
Federal government—Areas of use authorized by Treasury Board policy	
Human Resources Development Canada	**Other legislation and programs**
Canada Education Savings Grants	*Canada Elections Act*
Canada Labour Code	*Canada Wheat Board Act*
Canada Pension Plan	*Family Orders and Agreements Enforcement Assistance Act*
Canada Student Financial Assistance Act and Regulations	*Farm Income Protection Act*
Canada Student Loans Act	Immigration Resettlement Assistance Program
Employment Insurance Act	Income and Health Care programs (Veterans Affairs Canada)
Labour Adjustment Benefits Act	National Dose Registry for occupational exposures to radiation
Labour Adjustment Review Board	Rural and Native Housing Program (Canada Mortgage and Housing Corporation)
Old Age Security Regulations	Social Assistance and Economic Development Program (Indian and Northern Affairs Canada)
Canada Customs and Revenue Agency	Veterans Allowance Regulations
Excise Tax Act (Part IX—GST)	
Gasoline and Aviation Gasoline Excise Tax Application Regulations	
Income Tax Act	
Income tax appeals and adverse decisions	
Tax Rebate Discounting Regulations	
Other jurisdictions—some areas of use	
Health insurance	
Social assistance	
Welfare	
Workers' compensation	
Private sector	
Interest reporting to the Canada Customs and Revenue Agency (by, for example, banks, trust companies, stock brokers)	
Income tax identification	
Employer file number	
Client identification (for example, membership in video stores)	
Credit check (by, for example, car dealerships, department stores, cellular telephone companies, landlords)	

Source: Statistics Canada and Treasury Board Secretariat

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[redacted]
Federal government—Areas of use authorized by Treasury Board policy
Human Resources Development Canada Canada Education Savings Grants *Canada Labour Code* Canada Pension Plan *Canada Student Financial Assistance Act* and Regulations *Canada Student Loans Act* *Employment Insurance Act* *Labour Adjustment Benefits Act* Labour Adjustment Review Board Old Age Security Regulations **Canada Customs and Revenue Agency** *Excise Tax Act* (Part IX—GST) Gasoline and Aviation Gasoline Excise Tax Application Regulations *Income Tax Act* Income tax appeals and adverse decisions Tax Rebate Discounting Regulations **Other legislation and programs** *Canada Elections Act* *Canada Wheat Board Act* *Family Orders and Agreements Enforcement Assistance Act* *Farm Income Protection Act* Immigration Resettlement Assistance Program Income and Health Care programs (Veterans Affairs Canada) National Dose Registry for occupational exposures to radiation Rural and Native Housing Program (Canada Mortgage and Housing Corporation) Social Assistance and Economic Development Program (Indian and Northern Affairs Canada) Veterans Allowance Regulations
Other jurisdictions—some areas of use
Health insurance Social assistance Welfare Workers' compensation
[redacted]
Interest reporting to the Canada Customs and Revenue Agency (by, for example, banks, trust companies, stock brokers) Income tax identification Employer file number Client identification (for example, membership in video stores) Credit check (by, for example, car dealerships, department stores, cellular telephone companies, landlords)

Source: Statistics Canada and Treasury Board Secretariat

documents we examined also indicated that provinces and municipalities use the SIN in administering social assistance and other programs. In short, many organizations collect SINs from Canadians and then retain that information.

1.13 The widespread use of the SIN for many different purposes gives it a value that means it must be linked with only its rightful owner. When it is not, government benefits, tax refunds, or bank credit may go to the wrong person.

1.14 **Opportunities for SIN fraud.** According to HRDC, between 1964 and 1976 almost 19 million SINs were issued without requiring the applicants to provide proof of their identity. In 1976, the government began requiring that new applicants and card holders seeking replacement cards furnish documents such as birth certificates to prove their identity. Due to cost considerations, the government decided not to require the 19 million people who already had a SIN to register again with proof of their identity.

1.15 According to HRDC, the proof-of-identity requirements established in 1976 are no longer sufficient. New technologies have made it relatively easy to forge identity documents such as birth certificates. HRDC has anecdotal reports from the Royal Canadian Mounted Police, other police agencies, and its own employment insurance investigators that illustrate how easily fraud can be perpetrated and SINs issued that should not be issued. In addition, the plastic SIN card can be used as an identity document, although it has no modern security features and is easily forged. There is a wide range of fake documents available on the Internet, including birth certificates. The formula for generating a false SIN that will look like a valid one can also be accessed on the Internet.

1.16 **Impact of SIN fraud.** In 1998 we noted that obtaining a SIN fraudulently can be part of developing a false identity and an initial step in schemes to obtain government services or credit fraudulently or evade taxes.

1.17 In both Canada and the United States, identity fraud is a growing concern. The SIN and its U.S. counterpart, the social security number, can play an important role in this kind of crime. American authorities report that social security numbers, along with dates of birth and mothers' maiden names, are among personal identifiers often used in a wide range of identity-related frauds. These frauds can be steps toward far more serious crimes.

1.18 The Canadian Council of Better Business Bureaus reports that stolen identity is one of its top three concerns. Equifax Canada Inc., a consumer and commercial credit reporting company, states that the incidents of identity theft it handles increased from 4,000 cases in 1998 to over 12,000 cases in 2001. The U.S. Federal Trade Commission reported that in 2001 it processed more than 86,000 reports from victims of identity theft. In a recent report to Congress, the General Accounting Office concluded that the prevalence and cost of identity theft in the United States appear to be growing.

1.19 According to HRDC, the expanded use of the SIN by other levels of government and institutions has both increased the potential for SIN fraud and extended its impact. For example, once someone has established a false

identity that includes a SIN obtained fraudulently from HRDC, that identity can be used to access federal and provincial social programs, to defraud banks, and to misrepresent income to the Canada Customs and Revenue Agency. As the Web site of the Office of the Privacy Commissioner of Canada notes, a valid SIN can also be used to steal a real identity. It is possible to use someone else's SIN along with other personal information to apply for a credit card, open a bank account, and rent vehicles, equipment, or accommodation in that person's name, leaving the victim responsible for the bills, charges, bad cheques, and taxes. Exhibit 1.2 provides recent examples of the kinds of crimes in which the SIN has played a part.

Exhibit 1.2 Crimes involving the Social Insurance Number

While some of these issues are outside the direct control of the federal government, crimes involving SINs are a problem.

- An individual arriving in Canada applied for refugee status, which was denied. He began working illegally and subsequently applied for Employment Insurance benefits using his son's SIN card. The individual's common-law wife was also working illegally, using their daughter's SIN; his brother was committing the same crime, using his own son's SIN.
- An individual was caught making false documents and using them to impersonate individuals. At the time of his arrest, he had in his possession various fraudulent cards, including SIN cards with various names. With the false documents, he had been able to change the victims' personal identification numbers for access to their lines of credit, credit card accounts, and chequing and savings accounts. Using similar methods, he succeeded in obtaining thousands of dollars from two victims' bank accounts.

Source: Human Resources Development Canada

What we found in 1998

1.20 Our 1998 audit found that the SIN had become a common numerical identifier both inside and outside the federal government in a wide range of income-related transactions and benefits. We reported several weaknesses in the administration of the SIN, including the following:

- Information held by HRDC on SIN holders, particularly on births and deaths, was not always complete and accurate.
- Procedures to apply for a SIN were not sufficient to guard against fraud and abuse. Millions of SIN holders who had registered before the proof-of-identity program was introduced in 1976 had not been asked to furnish documents that proved their identity. This exacerbated the risk of misrepresentation.
- The provinces and financial institutions were required by the *Income Tax Act* and Regulations to collect SINs for tax purposes, but could not validate the SIN numbers provided by their clients.

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- The provinces and financial institutions were required by the *Income Tax Act* and Regulations to collect SINs for tax purposes, but could not validate the SIN numbers provided by their clients.

- SIN errors, abuse, and misuse affected many federal and provincial programs and the private sector. Collectively, the impact may have been sizable.
- HRDC was dedicating minimal effort to investigating SIN fraud and abuse, and penalties were minimal, with no real impact on deterrence.
- Unregulated use in the private sector (except in Quebec) made the SIN vulnerable to abuse—both fraud and invasion of privacy.

1.21 Our report contended that it was time to review the current role, objectives, and uses of the SIN in light of the important function it serves in government and society. The government needed to state clearly the level of integrity and protection of privacy expected in the system.

What has happened since 1998?

1.22 HRDC, the Canada Customs and Revenue Agency (CCRA), Citizenship and Immigration Canada, Industry Canada, and the Department of Justice Canada accepted our 1998 recommendations and observations. The Standing Committee on Public Accounts and the Standing Committee on Human Resources Development subsequently held hearings and issued reports to the House of Commons on the SIN. Both committees substantially agreed with our recommendations.

1.23 HRDC created five working groups to address our recommendations for better management of the SIN. These groups were made up of representatives of the departments involved in the SIN program: HRDC, the CCRA, and Citizenship and Immigration Canada. The working groups reported to HRDC in February 2000.

1.24 Our December 2000 follow-up reported that HRDC had taken several measures to improve the integrity of data in the Social Insurance Register; it had increased the number of SIN investigations and had other initiatives under way to address some of our 1998 recommendations. We indicated that a government-planned study on the impact and use of the SIN would provide essential information to help the government and parliamentarians make sound decisions about the future of the SIN, the advisability of restricting its use, matching of the data, and protection of privacy.

1.25 Early in fall 2001, HRDC submitted a plan to the Treasury Board for improving the management of the SIN. The Department advised the Treasury Board that without significant new funding it would be unable to improve the integrity of data in the Social Insurance Register to an acceptable level, assess the effectiveness of current SIN policies, make its proof-of-identity requirements more rigorous, increase the number of SIN investigations, or undertake a national public awareness campaign. According to HRDC, the new funds it later received were not enough to carry out these activities. It did not reallocate its resources to fund them.

Focus of the audit

1.26 The objective of our audit was to determine whether the government has safeguarded and strengthened the integrity of the Social Insurance Number. We examined its actions on the key concerns we raised in 1998 and the concerns of the Standing Committee on Public Accounts and the Standing Committee on Human Resources Development. More details appear in About the Audit at the end of the chapter.

Observations and Recommendations

Role and importance of the SIN

Use of the SIN outside the federal government

1.27 Responding in December 1999 to a recommendation by the Standing Committee on Human Resources Development, HRDC submitted a report confirming that the SIN's primary role was as a file number in the administration of authorized federal programs. The government rejected the idea of legislation to restrict the use of the SIN outside the federal government. Recognizing concerns about privacy of personal information, including the SIN, in the private sector, it introduced the *Personal Information Protection and Electronic Documents Act*.

1.28 That legislation provides Canadians with, among other things, the right to the protection of their personal information in the private sector. It defines the principles that govern the collection, use, and disclosure of personal information and provides a framework to address complaints of alleged breach of these principles. The Act (which will not be fully implemented until 2004) does not deal specifically with the SIN but captures it in the definition of personal information. It requires that an organization explain why it needs personal information and obtain the person's consent to use it. This could serve to limit the use of the SIN. Prohibiting its use outside of the federal government, however, was not included in legislation.

1.29 HRDC asked Statistics Canada to study the extent to which the SIN is used in the private sector but did not study its use in the voluntary sector or the public sector of the provinces and territories. The study by Statistics Canada concluded in February 2001 that SINs were being collected from employees and clients for a wide range of purposes. The study revealed the following:

- 94 percent of employers ask for a SIN when hiring an employee;
- 86 percent of employers do not know their obligations related to the SIN's 900 series (issued to applicants who are not Canadians or permanent residents and who cannot work in Canada without an employment authorization from Citizenship and Immigration Canada);
- 6 percent of all businesses surveyed and 27 percent of businesses with more than 250 employees have been given a false SIN by employees, although few reported any losses as a result;

- 10 percent of businesses surveyed have used SINs as employee file numbers;
- 14 percent of all businesses surveyed and 57 percent of businesses with more than 250 employees have used SINs to identify their employees' insurance and pension files;
- 19 percent of businesses surveyed have shared SINs with insurance companies that provide coverage to employees (only 5 percent did so at the request of the employee); and
- 9 percent of businesses surveyed have asked their clients for SINs and used them for a variety of purposes such as credit checks, proof of identity, and file numbers.

1.30 Partly as a response to these survey results, HRDC undertook a number of public awareness activities on the SIN. However, their scope was limited by their primary focus on certain clients of the Department, particularly Canada Pension Plan beneficiaries and visitors to local HRDC offices. The Department also placed information on its Web site. It did not take other measures that would have reached a larger public, such as using the national media. HRDC has not measured the public awareness campaign's effectiveness in informing individuals, employers, and other stakeholders about how and when to use the SIN.

1.31 **Recommendation.** Human Resources Development Canada should assess the public awareness of how and when to use the Social Insurance Number appropriately and should carry out public education efforts as needed.

HRDC's response. As the Auditor General notes, HRDC did undertake a range of public awareness activities during 2001 and 2002. These included brochures, information to clients, and changes to the message on the SIN card itself. HRDC will assess the effectiveness of its Social Insurance Number public awareness activities during 2002–03. The Department will use the results of that assessment to guide the next phase of its public education efforts that will begin in 2003–04.

Problems with the use of the SIN

1.32 The Treasury Board policy implemented in 1989 reflects the government's intention to restrict the use of the SIN by federal institutions to specified tax, pension, social, and benefits programs. The policy on the use of the SIN lists acts and regulations requiring its use and programs authorized to use the SIN. The Treasury Board Secretariat has not updated the policy governing the SIN since 1989.

1.33 Although the SIN has been studied from many aspects since 1998, what has not been assessed is how federal programs use it and to what extent they rely on it. HRDC, for example, requires the SIN of applicants for benefits in its large programs. However, it is unclear whether HRDC uses the SIN as simply a number to manage a recipient's file or also as a means to help establish recipient's identity.

1.34 Although the government has reaffirmed its policy that the SIN is simply a file number and therefore not a form of identification, it has not given departments direction on acceptable ways to identify program beneficiaries, except for on-line services. Properly identifying clients is a fundamental control in any government program.

1.35 The Treasury Board Secretariat became aware in 2000 that HRDC's Opportunities Fund for Persons with Disabilities program was using the SIN without Treasury Board authorization. Follow-up work by the Department and the Secretariat found two other HRDC employment assistance programs (Youth Initiatives and Aboriginal programs) using the SIN without authorization. During our audit, the Department was attempting to remedy the situation by working closely with the Treasury Board Secretariat. It received the support of the Privacy Commissioner for using SINs in these programs.

1.36 Further to its work in HRDC, the Secretariat decided to review whether federal institutions are respecting the policy that governs the use of the SIN. It will also consider revising the policy and developing guidelines for all federal institutions. The Secretariat expects to report the results of its review to the Treasury Board by June 2003.

1.37 **Recommendation.** Human Resources Development Canada should use the SIN only where authorized by the Treasury Board.

HRDC's response. HRDC is working with the Treasury Board Secretariat and the Privacy Commissioner of Canada to include the three programs to which the Auditor General refers on the list of authorized uses. This will enable HRDC to fulfil its commitment to full compliance and underline the fact that the SIN is intended to serve solely as a file identifier for Government of Canada-related purposes.

1.38 **Recommendation.** In its review, the Treasury Board Secretariat should look at why and how departments are using the SIN.

Treasury Board Secretariat's response. During its review, the Treasury Board Secretariat will closely examine the uses of the SIN by federal institutions and will make every effort to resolve any issues related to the Treasury Board policy concerning the SIN.

Integrity of the issuing process

Applying for a SIN

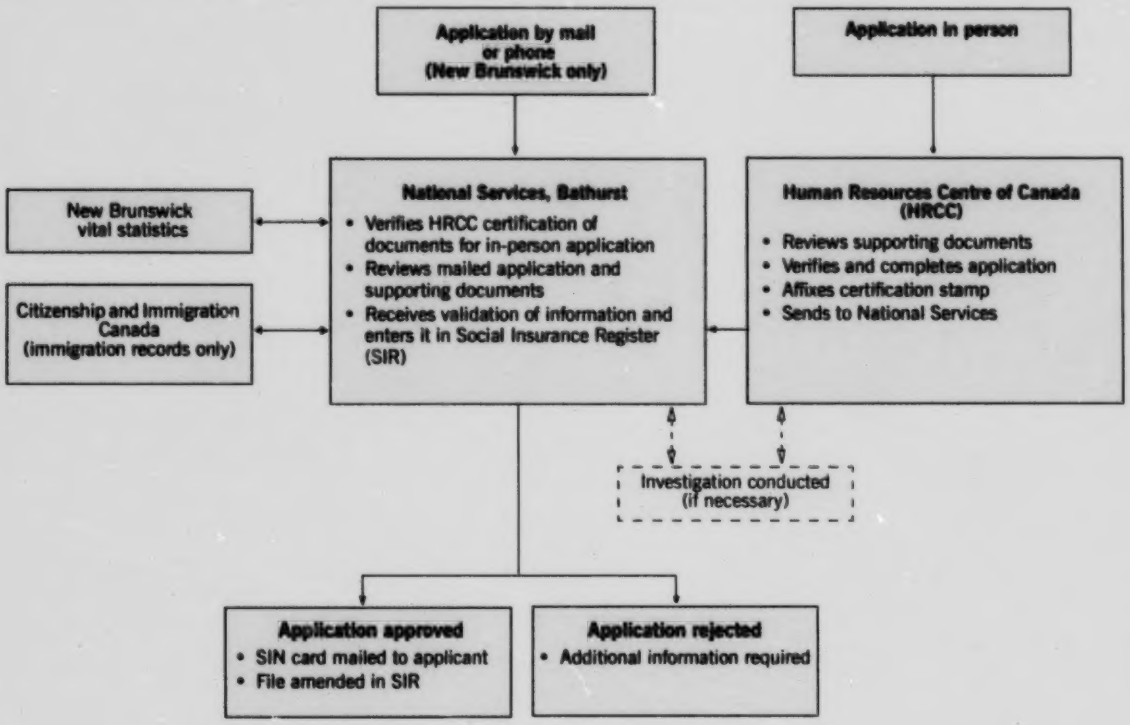
1.39 An application for a SIN is generally presented in person at one of the 320 Human Resources Centres across Canada. An HRDC representative reviews the application for completeness and examines the document offered as proof of identity and status in Canada. The representative records relevant information from the document submitted and then stamps and initials the application. The stamp indicates to the Department's National Services in Bathurst, New Brunswick (which issues all SIN cards) that 1 of the 38 acceptable documents has been seen and the application is complete, accurate, legible, and valid. The application is then sent to National Services for review and for input in the Social Insurance Register, and the card is

issued. Applications can also be mailed directly to National Services with an original document or a certified photocopy. The process is illustrated in Exhibit 1.3.

1.40 Over 1.2 million applications are processed each year; about 1 million new SINs are assigned and about 200,000 replacement cards issued. Since 1998 the Department has issued over 3.7 million new and replacement SIN cards.

Exhibit 1.3 Processing a SIN application

SIN applications are made, for example, to request a SIN, a replacement card, or a change of name or status.


Application by mail or phone (New Brunswick only)
Application in person
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Citizenship and Immigration Canada (immigration records only)
National Services, Bathurst
• Verifies HRCC certification of documents for in-person application
• Reviews mailed application and supporting documents
• Receives validation of information and enters it in Social Insurance Register (SIR)
Human Resources Centre of Canada (HRCC)
• Reviews supporting documents
• Verifies and completes application
• Affixes certification stamp
• Sends to National Services
Investigation conducted (if necessary)
Application approved
• SIN card mailed to applicant
• File amended in SIR
Application rejected
• Additional information required

SINs are issued without proper control

1.41 We expected to find that HRDC was meeting the requirements of the *Employment Insurance Act* and Regulations in issuing SINs and that it had strengthened its controls over SINs. Instead, we found serious weaknesses in the issuing of SINs, and in our view HRDC is not doing enough to safeguard the SIN's integrity.

1.42 In our view, HRDC's policies and practices do not meet, in important respects, the intent of the *Employment Insurance Act* and Regulations. Under the Act, the Canada Employment Insurance Commission is required to identify accurately all persons to whom it assigns a SIN. The Regulations to

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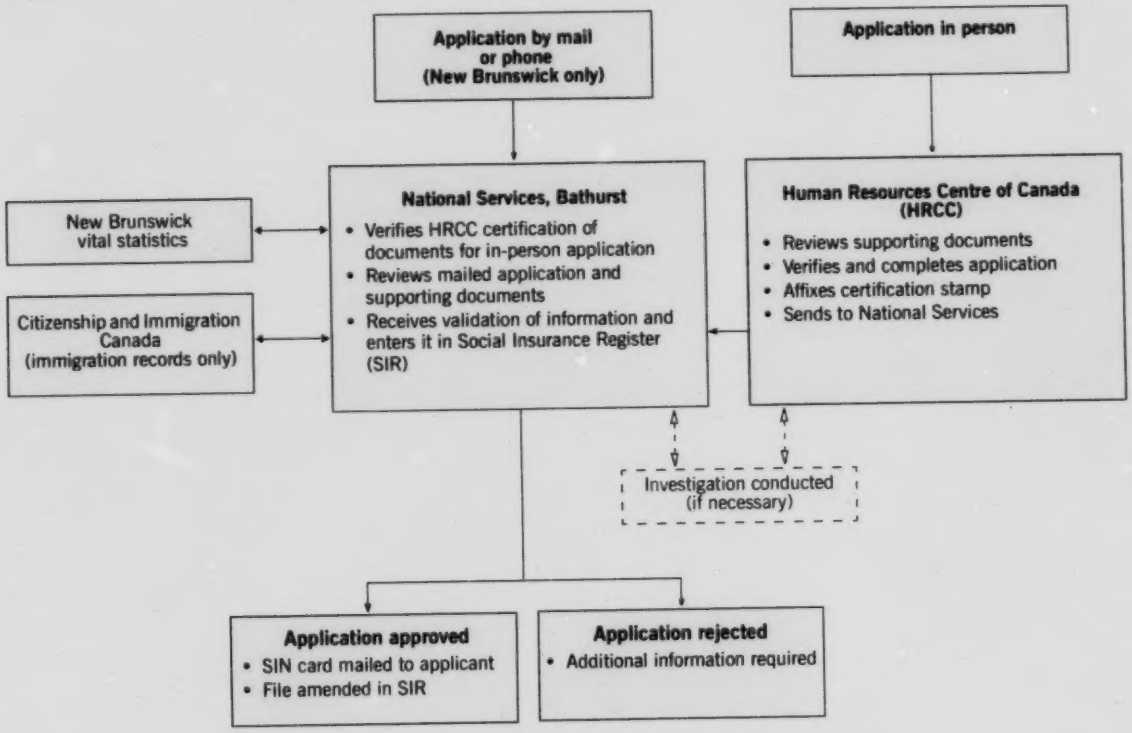
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the Act specifically require HRDC to determine both the identity and the citizenship status of SIN applicants. However, HRDC currently requires that a SIN applicant be asked for only one document as proof of both identity and citizenship. Many of the 38 different documents that HRDC accepts, such as birth certificates, cannot be linked to the person applying for a SIN. A document may show citizenship status, for example, but has no photograph or description of the owner to help identify the bearer of the document as its owner. In our opinion, determining identity properly would mean requiring additional identification. Consequently, our view is that HRDC's policies and practices do not respect the intent of the *Employment Insurance Act* or Regulations. We are concerned that for the majority of the SINs issued since 1998, the applicant's identity and citizenship status were not checked properly because a single piece of identification is usually insufficient to check both.

1.43 In 1998 we observed that many of the documents HRDC was accepting had significant drawbacks. We recommended that the Department assess the reliability of identity documents used to support applications for a SIN and that it take corrective action where needed. In our audit this year, we found that the Department had done little to strengthen its process of issuing SINs and was still reconsidering its approach to proof of identity and citizenship. It was accepting Quebec baptismal certificates or birth certificates issued before 1994, although the Government of Quebec had asked it to stop accepting these certificates because they are difficult to authenticate and could have been falsified. HRDC was also accepting as proof of identity and citizenship other documents with higher risk of falsification, such as expired Canadian passports no matter how old. However, at the end of our audit HRDC announced that it would stop accepting these documents as of August 2002, in order to strengthen the SIN proof-of-identity requirements.

1.44 As already noted, HRDC does not require applicants to submit documents in the original; it accepts photocopies that have been certified as true copies by people in a wide range of occupations. The Department does not check the information, even on a sample basis, with the people who have certified the photocopies it accepts. In our view, photocopies represent a greater risk of falsification. Moreover, accepting photocopies circumvents one of the key controls in the processing of applications—the comparison by HRDC staff of documents presented by applicants with pictures of authentic documents and descriptions of their security features.

1.45 For the most part, the Department does not have the means to contact the authority that issued the documents to check their validity. Exceptions are the checking of immigration documents with Citizenship and Immigration Canada and of birth certificates with the Vital Statistics Branch of New Brunswick's Department of Health and Wellness—which together account for about 30 percent of applications that HRDC processes. These checks verify that the document is valid but do not confirm that the bearer of the document is its rightful owner.

1.46 We also found that the Department's policies on issuing SINs focus less on safeguarding the integrity of the application process and more on satisfying the applicant. For example, HRDC staff are advised to use discretion when they attempt to confirm an applicant's identity if presented with documents of questionable validity, in case the applicant views their attempts as harassment. Moreover, HRDC's rules are unclear in many respects and are therefore subject to misinterpretation. We found examples of contradictory statements and ambiguous instructions.

1.47 During our audit, HRDC completed a study to identify ways to improve how it issues SINs while reducing the processing time. The Department informed us that it intends to use the results of this study in its planned changes to its process.

Staff lack adequate training, tools, and information

1.48 All HRDC staff should be processing SIN applications in a consistent way. However, we found that job responsibilities, training, tools, and information for issuing SINs vary greatly among local HRDC offices. There is a risk that how much attention a SIN application receives depends on where it is submitted and who processes it.

1.49 Responsibilities may not be understood clearly. For example, while all staff are responsible for fraud detection, most front-line staff we interviewed said they tend to rely on National Services in Bathurst to detect fraud. For applications handled initially by HRDC's local offices, however, National Services relies on the local staff to detect fraud. And despite high rate of turnover in some offices, no formal training is given to staff before they start handling applications. Computer-based training is available on the Department's internal network. However, we observed in the offices we visited that new employees were often left to learn on the job.

1.50 HRDC has made some progress in providing staff with tools for fraud detection. For example, it introduced risk indicators for staff of local offices to use on incoming applications. It also issued a guide containing pictures and descriptions of security features of authentic documents for comparison with documents presented by applicants. In early 2002, it supplied regional offices with ultraviolet lamps (to help detect fraudulent documents) for distribution to all local offices. When we visited local offices, however, we noted that some had not obtained the lamps and that generally staff had received no training in their use.

Inadequate control over SINs issued to applicants who are not Canadians or permanent residents

1.51 HRDC also issues SINs to short-term visitors, refugee claimants, seasonal workers, and foreign students. A SIN can also be issued to citizens of other countries, even if they are not visiting or residing in Canada. These numbers begin with a 9 to distinguish them from regular SINs and to indicate that the bearer requires separate authorization to work in Canada. When a person who has been issued a 900-series SIN is granted Canadian citizenship or becomes a permanent resident and applies for a regular SIN, HRDC

cancels the 900-series SIN and assigns a regular number in its place. Over time, HRDC has issued close to 1.6 million 900-series SINs. At the end of 2001, the Social Insurance Register showed more than 900,000 of these SINs that had not yet been cancelled.

1.52 Since our 1998 audit, the Department has made no changes in the way it controls the 900-series SINs. We found that, as in the case of regular SINs, HRDC does not take adequate steps to establish the identity of people who apply for 900-series SINs. It requires only one document to prove both identity and citizenship. It will accept any one of a range of documents produced by the Government of Canada (such as immigration forms) and by foreign governments (such as passports). While passports demonstrate both identity and citizenship, many other documents do not. And staff have no training or tools to verify the validity of documents issued by foreign governments. Moreover, HRDC will accept photocopies of these documents (including foreign passports). Detecting fraud is more difficult when working with photocopies.

1.53 Furthermore, under the Regulations to the *Employment Insurance Act*, HRDC is supposed to require applicants for 900-series SINs to show why they need one. Some of the identity and citizenship documents HRDC accepts (for example, an authorization to work in Canada) might suggest why the person would need a SIN, but most indicate only that the person is allowed to be in Canada. We found that the Department does not require staff to get an explanation from all 900-series applicants as to why they need a SIN (see the case study below). Since 1998 the number of 900-series SINs assigned each year has been increasing. According to HRDC, this trend is consistent with the changes that Citizenship and Immigration Canada has reported in the temporary resident and refugee claimant population. In 2001, over 110,000 of the 900-series SINs were issued; this was 41 percent more than in 1998.

Processing 900-series SIN applications

This case illustrates the frustrations that some staff face at Human Resources Centres of Canada in processing 900-series SIN applications.

A front-line worker in a large Canadian city began to question why individuals who were in Canada as visitors for short periods of time were requesting and receiving SIN cards. Despite expressing concern that SINs were being issued to individuals who did not need them, he was instructed by management to process the applications. He did, but submitted them to National Services without including the required certification stamp or the numbers of the submitted documents and provided for each application a photocopy of the passport and the entry stamp, hoping that this would cause National Services to reject the applications. National Services did not reject the applications; it approved them and issued the SIN cards to visitors to Canada.

1.54 As in 1998, the 900-series numbers and the cards do not expire. Most people holding them are expected either to be in the country only temporarily or to gain permanent status in Canada and be granted a regular number. We noted during our audit, however, that more than 60 percent of 900-series

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SINs that have not been cancelled were issued more than five years ago. It is likely that the original holders have left the country, but there is no way of knowing what happened to their cards.

1.55 **Recommendation.** Human Resources Development Canada should ensure that its policies and practices respect the intent of the *Employment Insurance Act* and Regulations, which require it to

- determine the identity and citizenship status of applicants for a Social Insurance Number; and
- obtain proof of the need for a Social Insurance Number from applicants who are not Canadian citizens or permanent residents.

1.56 **Recommendation.** Human Resources Development Canada should reconsider its goals for the 900-series SIN and the associated risks. It should revise its policy and practices accordingly.

1.57 **Recommendation.** Human Resources Development Canada should improve the integrity of its SIN application process. In particular, it should

- assess the reliability of the identity and citizenship documents it accepts as support for applications and implement corrective action where necessary;
- make reasonable efforts to develop a means of checking the validity of identity and citizenship documents with the authorities that issued them; and
- ensure that staff have the training and tools to comply with the *Employment Insurance Act* and Regulations when they process applications for a Social Insurance Number.

HRDC's response. HRDC is building on previous initiatives to improve the integrity of the issuing process to ensure that it is meeting the Social Insurance Number goals of the *Employment Insurance Act*.

As of August 1, 2002, the Department implemented a uniform standard for Canadian-born applicants when it stopped accepting baptismal certificates from applicants born in Quebec and Newfoundland and Labrador. HRDC will build on this step by implementing its decision to render certified photocopies ineligible as proof of identity by November 1, 2002. This means that HRDC will accept only original documents to prove identity for applications made in-person or through the mail. The Department will accelerate the necessary training of staff on policies and procedures, including the new proof-of-identity requirements. Initiatives such as the use of ultraviolet lights to examine original documents, and improved staff training, enhance HRDC's security measures.

In February 2002, the Department reviewed how SIN applications are processed and is considering ways to further strengthen proof of identity, such as implementing a guarantor system similar to the one used for the Canadian passport; or including photo identification as part of the application process.

HRDC will continue with efforts that it has been making since 1998 to access vital statistics databases of the provinces and territories. It should be recognized that, with privacy and security concerns, these partnerships take time. Eventually, as is the case right now in New Brunswick, this will allow the Department to directly, accurately, and consistently verify birth information provided by Canadian-born SIN applicants with the province or territory of birth. HRDC is currently working toward a pilot project with British Columbia to verify the information provided on a SIN application with the provincial vital statistics agency.

HRDC is taking steps to amend the Employment Insurance Regulations to improve the management of SINs needed by people who are neither Canadian citizens nor permanent residents (900-series). Under this change, these 900-series SINs will be limited to an amount of time that is linked to the individual's authorized stay in Canada, rather than indefinitely. These SIN cards will display the expiry date of that Social Insurance Number.

HRDC also recognizes the need to address the issue of existing 900-series SINs. In order to bring about consistency, and after regulatory approval is obtained, existing 900-series SIN cardholders will have a reasonable period of time to provide acceptable proof of identification and proof of need to obtain a new card.

The Department anticipates that these measures represent additional significant improvements in the overall security and accuracy of the Social Insurance Number database.

Integrity of the Social Insurance Register

1.58 The Social Insurance Register is the database that records the personal information provided by individuals who apply for a SIN. It contains all the SINs issued so far and basic personal information such as name, date of birth, father's name, and mother's maiden name. In 1998 we reported that the integrity of the Register was a major concern. We expected to find in this audit that HRDC had largely resolved this concern and ensured that the information in the Register was reasonably accurate and complete.

Action taken to date

1.59 In 1998 we recommended that HRDC set out a plan for bringing the reliability and completeness of the Register up to an appropriate level. In 2002 we found that the Department has not carried out a comprehensive approach for improving the integrity of the information. According to HRDC, a lack of funding prevented it from implementing the improvement plan it had originally developed in response to our 1998 concerns. At the end of our audit, there was still no standard for the quality of information in the Register.

1.60 Nevertheless, HRDC has attempted to improve the Register through various initiatives. The Department has compared data in the Register with the Old Age Security and Canada Pension Plan (CPP) records of almost 10 million people, and personal information has been updated accordingly.

This included

- cross-checking CPP and Old Age Security files against at least 3 million SIN records for which HRDC had never obtained proof of identity;
- noting on 101,000 SIN records that the individual had died; and
- changing about 276,000 incorrect dates of birth.

1.61 The Department undertook various initiatives to obtain more accurate information on deaths. Since 1998, it has received over 4.8 million death notices from different sources, such as the Canada Customs and Revenue Agency and the Old Age Security and Canada Pension Plan programs.

1.62 The Department also implemented SIN Tele-App which allows clients in New Brunswick to apply for a SIN by telephone. Their information is validated against the database at the Vital Statistics Branch of New Brunswick's Department of Health and Wellness or against Citizenship and Immigration Canada's immigration database.

1.63 HRDC has built into its system some indicators to detect potentially fraudulent applications. However, it could add other indicators of unusual activity, such as SIN cards mailed to a post office box, cards returned to National Services and never claimed, or multiple cards sent to the same address. A special study by the Department in 2001 found that in many cases HRDC had mailed more than 100 SIN cards (with different numbers) to a single address over a period of a year (including 225 cards to one address). Because the Department does not track such activities, it did not detect these events as it processed the applications; nor did it investigate them afterward.

Information in the Register can be improved further

1.64 One of the main difficulties in maintaining the Register is that HRDC is not advised routinely of births or changes of name. Although HRDC receives death notices from many sources, it indicates that this information is not comprehensive. The integrity of the Register would be improved if the Department had access to provincial and territorial vital statistics. During our audit, HRDC initiated discussions on this subject with the Vital Statistics Council, an interjurisdictional advisory group comprising the heads of the vital statistics divisions/agencies from all the provincial and territorial governments and the Health Statistics Division of Statistics Canada. The Council provides a forum for developing common approaches to collecting vital statistics, sharing information with outside parties, and facilitating problem solving for issues related to vital statistics.

1.65 However, HRDC has not pursued other sources of information that could improve the Register. For example, it lacks formal agreements with federal departments that issue identity and citizenship documents, such as citizenship cards and passports. While HRDC compares monthly Register data with Old Age Security data, it has not yet done so with the Canada Pension Plan or the Quebec pension plan (Régime de rentes du Québec). At the end of our audit, HRDC was involved in discussions with the CPP and

the Quebec pension plan. As already noted, HRDC has made efforts to improve the Register's information on deceased people. However, many of the death notifications it receives are not checked with provincial or territorial vital statistics.

Dormant file review

1.66 HRDC classified over 3.2 million SINs as dormant after obtaining evidence from the Canada Customs and Revenue Agency that the SINs belonged to people over the age of 23 who had not filed a tax return, or for whom no income had been reported from 1993 to 1997.

1.67 The intent of this exercise was to help explain the gap between the number of SINs and the population and to flag SINs for greater scrutiny if the Department were to receive an application for a replacement card or any other changes. Until May 2002, however, National Services was processing transactions involving dormant SINs without investigating them. It simply removed the dormant marker from the file and took no special action to ensure that the transaction was legitimate.

1.68 In May 2002, HRDC began routinely investigating SIN-related transactions in dormant files. These dormant SINs can still be used as a first step to access benefits such as Employment Insurance, Canada Pension Plan, and Old Age Security—because federal programs that use SINs are not informed of those that are dormant. HRDC advised us that other information in addition to the SIN is required to establish eligibility for its benefits or entitlement to them.

1.69 The Department has found problems in the way the dormant file exercise was carried out. For example, the results excluded SINs that should have been identified as dormant: they did meet the screening criteria. In our view, the identification of dormant SINs has done little so far to reduce the gap between the number of usable SINs and the size of the population. By a usable SIN, we mean one that can be used as an account number in transactions with the federal government and not raise any concern or suspicion in itself.

Problems with information integrity persist

1.70 There are still significant discrepancies between the number of usable SINs and Statistics Canada's estimates of the Canadian population over 20 years old. While the Social Insurance Register is not a census of the Canadian population and comparing it with Statistics Canada's census presents some problems, the question remains: Why would there be millions more usable SINs than Canadians who could use them?

1.71 These discrepancies concern us, as they did in 1998. Despite HRDC's efforts to improve its information on SIN holders, the Register still contains significant variances from population estimates—variances that have increased over the past four years (Exhibit 1.4). While excluding the dormant SINs would reduce these discrepancies from 5 million to 2.4 million, we

included them in the exhibit because they are still usable as a first step to access federal benefits. In HRDC's view, dormant SINs are unlikely to be used in the future.

1.72 However, even with the dormant SINs removed, 2.4 million is a significant gap. The Department suggests that these excess SINs probably represent people who have left the country (most often, holders of 900-series SINs), deaths of which HRDC has not been notified, people with multiple SINs, and frauds; or they could reflect the timing of the census. In our view, HRDC needs to explain the variances fully.

Exhibit 1.4 Comparing the Social Insurance Register with the population (2001 Census)

Age	Usable SINs in the Social Insurance Register	Population based on Statistics Canada's 2001 Census	Variance
20–29	4,378,563	3,854,010	524,553
30–39	5,390,632	4,619,595	771,037
40–49	5,838,149	4,912,295	925,854
50–59	4,656,062	3,679,995	976,067
60–69	2,899,245	2,407,405	491,840
70–79	2,153,021	1,822,880	330,141
80–89	1,102,428	797,925	304,503
90 years or more	829,687	134,120	695,567
Total	**27,247,787**	**22,228,225**	**5,019,562**

Source: Human Resources Development Canada and Statistics Canada

1.73 Another issue identified in this audit is the number of SINs that have never been cross-checked with other departments or supported by any proof-of-identity documents. These SINs were issued before the introduction in 1976 of the proof-of-identity program. The SIR shows over 8.3 million of these usable SINs. This represents a significant decrease from 1998. HRDC has accomplished this mainly by obtaining information from the CPP and Old Age Security programs. Due to the cost and inconvenience to SIN holders, HRDC does not plan to certify the remaining SINs systematically but only when there is a new transaction. However, it hopes it will be able to certify many more of these SINs if and when it is given access to provincial and territorial vital statistics or other official sources of information.

HRDC needs to better report on its improvements to the Register

1.74 We are concerned that HRDC reported the improvements it has made to the Social Insurance Register in a way that could be misinterpreted.

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Total	**27,247,787**	**22,228,225**	**5,019,562**

Source: Human Resources Development Canada and Statistics Canada

1.73 Another issue identified in this audit is the number of SINs that have never been cross-checked with other departments or supported by any proof-of-identity documents. These SINs were issued before the introduction in 1976 of the proof-of-identity program. The SIR shows over 8.3 million of these usable SINs. This represents a significant decrease from 1998. HRDC has accomplished this mainly by obtaining information from the CPP and Old Age Security programs. Due to the cost and inconvenience to SIN holders, HRDC does not plan to certify the remaining SINs systematically but only when there is a new transaction. However, it hopes it will be able to certify many more of these SINs if and when it is given access to provincial and territorial vital statistics or other official sources of information.

HRDC needs to better report on its improvements to the Register

1.74 We are concerned that HRDC reported the improvements it has made to the Social Insurance Register in a way that could be misinterpreted.

1.75 In its March 2000 *Performance Report*, HRDC said it had closed the gap between the number of SINs and the population to 800,000. It arrived at that figure by assuming that all holders of dormant SINs had died or left the country, although it had no proof that either was the case. Moreover, the identification of dormant SINs simply provided a possible explanation for a large portion of the gap between data in the Register and population estimates at that time. HRDC had taken no steps to actually reduce or close the gap. The dormant SINs could still be used as a first step to access benefits.

1.76 In its December 1999 response to the Standing Committee on Human Resources Development, HRDC implied that by identifying dormant SINs it had reduced the number of uncertified SIN records by 2.6 million. In our view, there is no relationship between dormant SINs and uncertified SINs. Dormant SINs are those that have not been used for some time, whereas uncertified SINs are those for which the personal information has not been verified. Declaring a SIN to be dormant does not somehow validate the personal information that HRDC has on record.

1.77 **Recommendation.** Human Resources Development Canada should set goals for the completeness and reliability of the Social Insurance Register and take the steps necessary to meet them.

HRDC's response. HRDC has made numerous improvements to its Social Insurance Number database, the Social Insurance Register (SIR), to make it more complete and reliable. Since 1998, HRDC has certified the accuracy of millions of SIN records. The Department has also identified 3.2 million other SINs that have not been used in at least five years, which includes 600,000 SINs of deceased individuals. HRDC conducts investigations as appropriate if someone then uses those Social Insurance Numbers to apply for Employment Insurance or is seeking a replacement SIN card.

To provide greater security, HRDC is taking steps to amend the Employment Insurance Regulations to cancel SINs that have not been used in five years. Once a SIN is cancelled, a person will be required to provide acceptable proof of identity to reactivate that SIN.

The Department has initiated a comprehensive review of the Social Insurance Register. That review will assist HRDC to set goals for SIR integrity, define the actions and timeframes needed to meet those goals, and implement the additional required changes. This process will be completed by April 2003.

1.78 **Recommendation.** Human Resources Development Canada should ensure that its reporting of improvements to the quality of the information in the Social Insurance Register is clear and unambiguous.

HRDC's response. HRDC agrees that reporting should be clear and accurate. It has already started to review this reporting to ensure that it provides information as clearly as possible.

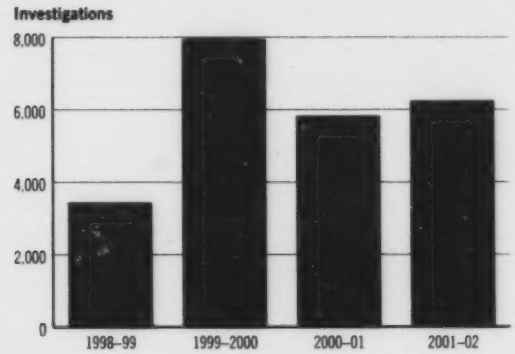
Investigating fraud

A risk-based approach to investigation and control is needed

1.79 We expected that HRDC would link its fraud investigations to the risks associated with the issuing of the SIN and with its use by the federal government.

1.80 Instead, we found that HRDC has completed no risk-based analysis of the SIN program. Nor has it attempted to determine the extent and nature of SIN-related fraud. Its level of effort is based mainly on the number of SINs issued, the resources it has available, and a number of specific risk indicators. Although the number of SIN investigations has increased since 1998 (Exhibit 1.5), it is not clear that this effort was focussed on high-risk areas. Furthermore, since current levels of effort reflect the supplementary funding the Department received, SIN investigations may not remain at this level after this funding ends in 2002–03.

Exhibit 1.5 Completed investigations of suspected SIN fraud



Source: Human Resources Development Canada

1.81 In 1998, we recommended that HRDC redesign its performance indicators for SIN investigations to recognize their importance not only to the Employment Insurance program but also to other federal programs and provincial, territorial, and municipal programs. In 2001–02, HRDC began the setting of goals and the routine tracking of the number of SIN investigations carried out by its local offices. This performance indicator does not capture information on the quality and results of those investigations. However, since 1998 the SIN Investigation Service has reviewed most SIN investigations for completeness.

1.82 Recommendation. Human Resources Development Canada should adopt a more comprehensive risk-based approach to investigating SIN-related fraud.

HRDC's response. The Department has implemented the SIN Application Review Program (SARP), a risk-based program that guides investigation priorities related to SIN applications, which forms part of HRDC's approach to risk management. The Department will determine if SARP can be

expanded to guide priority-setting for other SIN investigations. Any risk-based approach will recognize that the Department needs to work closely with federal and provincial government officials, police services, employers, and other partners in combating SIN-related fraud and abuse.

Investigators lack structured training and adequate tools

1.83 In this audit, we expected to find that SIN investigators were receiving more training and support than in 1998. However, we found that there is still no formal training program. While they now have access to some computer-based training, investigators informed us that they would benefit from classroom instruction.

1.84 We also expected that SIN investigators would have access to adequate tools. We found that various tools are being made available: on-line access to certain databases, a guide containing pictures and descriptions of security features of authentic documents, and ultraviolet lamps to help identify fraudulent documents. However, as we found with front-line staff, investigators in many of the local offices we visited had not yet received the lamps and some had not received training in the use of the tools.

1.85 **Recommendation.** Human Resources Development Canada should ensure that investigators have the proper training and tools.

HRDC's response. HRDC agrees with the recommendation. The Department has developed an integrated course on Social Insurance Number investigation and identity fraud. The first session of the course will take place in the fall of 2002. All HRDC offices have now received ultraviolet lamps and the necessary instructions and training to help identify fraudulent documents through their use. This is matched by a regularly-updated guide to identity documents. The decision that HRDC will no longer accept certified photocopies to prove identity from people applying for SINs in-person or through the mail will increase the effectiveness of these tools.

Conclusion

1.86 The SIN is used widely outside the federal government as well as inside. It is one of a handful of personal identifiers that a person needs to function in Canadian society. It is used in several major federal benefits programs and in transactions with the Canada Customs and Revenue Agency. It is used often, but not always, by provinces, cities, and the financial services industry. It also appears that many businesses use it when offering credit to their clients. All of these uses give the SIN its value.

1.87 We began our audit expecting to find that the issues we raised in 1998 had been substantially addressed. Instead, we have concluded that HRDC has not done enough to safeguard and strengthen the integrity of the SIN.

1.88 Ensuring that SINs are issued to only those eligible is still problematic. Most of the application-processing weaknesses we found in 1998 have not been addressed. In our view, HRDC's policies and practices do not meet, in

important respects, the intent of the *Employment Insurance Act* and Regulations. We are concerned that for the majority of the SINs issued since 1998, the applicant's identity and citizenship status were not checked properly because a single piece of identification is usually insufficient to check both.

1.89 The integrity of the Social Insurance Register also remains a persistent problem. While HRDC made a number of improvements after 1998, there are still several weaknesses that it has not dealt with adequately. The number of usable SINs for people over 20 years old exceeds the census figure by 5 million. Although HRDC has designated millions of SINs as dormant, they could still be used to access federal benefits programs without triggering an investigation. Finally, there are still 8.3 million records in the Social Insurance Register that have never been cross-checked with other departments or supported by any proof-of-identity program. These uncertified SINs are also usable.

1.90 Since 1998 the Department has stepped up the number of SIN-related fraud investigations. However, there is little basis for judging whether the new level of effort is adequate—because there is little information on the extent of SIN-related fraud. The Department has not done a comprehensive risk analysis as a basis for its investigation efforts.

HRDC's comments. HRDC is committed to fulfilling its role as part of the overall Government of Canada response to Canadians' heightened awareness of security issues. The Department recognizes the priority of addressing the security issues related to personal identification documents and has responded with actions that will strengthen its ongoing efforts to

- ensure appropriate issuance of SINs;
- improve the integrity of the key SIN database, the Social Insurance Register;
- vigorously pursue SIN fraud and abuse; and
- raise awareness that the Social Insurance Number (SIN) is authorized only as a file identifier for specific Government of Canada-related purposes and how to protect against SIN misuse.

HRDC is dedicated to diligent stewardship of the Social Insurance Number. Since 1998 the Department has taken steps to improve the management of the SIN and the integrity of the Social Insurance Register (SIR). The Department agrees with the recommendations in this chapter, and as indicated in its responses, is taking immediate action to implement a number of key initiatives. These actions will improve the policies, processes, and practices of its management and administration of the Social Insurance Number. We will continue to work with the Office of the Auditor General and other partners on further initiatives that fully meet the recommendations of the report and the expectations of Canadians.

About the Audit

Objective

The objective of our audit was to determine whether the federal government was safeguarding and strengthening the integrity of the Social Insurance Number (SIN). We assessed the extent of the government's action to address the key concerns we raised in our 1998 audit and those raised by the Standing Committee on Public Accounts and the Standing Committee on Human Resources Development.

Scope

Using the problems we identified in 1998 as a baseline, we tested whether they still existed and were still significant in 2002. We looked at four issues:

- the role and importance of the SIN;
- the integrity of the information in the Social Insurance Register (SIR);
- control over the issuing of SINs and the SIN cards; and
- efforts to combat fraud.

We carried out our audit mainly at HRDC headquarters in the National Capital Region; at Bathurst and Moncton, New Brunswick; in regional and local HRDC offices; and at the Treasury Board Secretariat. We gathered additional information from the Canada Customs and Revenue Agency, Citizenship and Immigration Canada, the Office of the Privacy Commissioner, Statistics Canada and the Royal Canadian Mounted Police.

Criteria

Legislative and other authorities should provide a sound framework for safeguarding and strengthening the integrity of the SIN.

Human Resources Development Canada should be aware of how the SIN is used in the private sector and the public sector in provinces and should lead action to encourage its proper use.

The Treasury Board Secretariat should monitor departmental compliance with its policies on the use of SIN and data matching.

HRDC should make reasonable efforts to ensure that it provides new SINs and replacement cards only to eligible individuals.

HRDC should make reasonable efforts to ensure that the Social Insurance Register is accurate, complete, and secure.

Fraud detection and investigation efforts should be based on risk.

Ratings

We assessed the action of departments/agencies against our original audit recommendations (see Key Message at the beginning of the Chapter). We used the following ratings:

- **Completed.** Corrective action has been fully implemented
- **Satisfactory progress.** Progress is being made at a satisfactory pace
- **Limited progress.** Some progress is being made, but the pace or scope is not satisfactory
- **No progress.** No evidence of progress although the department or agency accepted the recommendation from the original audit
- **Rejected.** The department or agency did not accept the recommendation from the original audit
- **Unknown.** Status of progress is unknown or information is not available

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The audit work reported in this chapter was conducted in accordance with the legislative mandate, policies, and practices of the Office of the Auditor General of Canada. These policies and practices embrace the standards recommended by the Canadian Institute of Chartered Accountants.

Table of Contents

Key Message 1

Introduction 3

Health surveillance: Essential for public health activities 3
Concerns we raised in 1999 4
Focus of the follow-up 4

Observations and Recommendations 5

Improving collaboration on national health surveillance 5
Progress in developing a national framework 5
An established approach to national health surveillance is still many years away 6
Lack of agreement on roles and responsibilities 7

Priority setting and business planning 9

Weaknesses in existing disease surveillance systems 9
Communicable disease surveillance: Improvement has been inconsistent 10
Steps to improve communicable disease information: The Canadian Integrated Public Health Surveillance Project 12
Chronic disease surveillance: Limited progress 14

Gaps in national health surveillance activities 15

Surveillance issues that need to be resolved 20
Lack of financial capacity to establish chronic disease surveillance systems 21
Lack of financial capacity to maintain chronic disease surveillance systems 21
Erosion of financial capacity 21
Priorities need to be established and supported with funding 23

Keeping Canadians safe: Food-borne disease and blood-borne pathogens 24
National surveillance of enteric diseases 24
National surveillance of blood-borne pathogens 24

Measuring and reporting performance 25

Standing Committee on Public Accounts 26

Conclusion 26

About the Follow-Up 28

Health Canada
National Health Surveillance

Assistant Auditor General: Maria Barrados
Principal: Patricia MacDonald

Key Message

2.1 Health Canada has made limited progress toward resolving some of the weaknesses identified in our 1999 audit. However, national surveillance is still weak; many systems still lack timely, accurate, and complete disease information; and gaps in surveillance continue. These weaknesses, taken together, compromise Health Canada's ability to anticipate, prevent, identify, respond to, monitor, and control diseases and injuries. Further, they compromise its ability to design, deliver, and evaluate public health activities.

ORIGINAL ISSUES	PROGRESS	RATING*
2.2 Health Canada should provide strong leadership and address factors that are compromising its ability to engage in national health surveillance: • Lack of federal public health legislation or a national framework to link the separate public health activities in the provinces and territories. • No agreement among the various partners on clearly defined roles and responsibilities in the areas of data collection and dissemination and responding to public health threats.	Health Canada is taking a greater leadership role in national health surveillance: • It has made progress in establishing a national framework for health surveillance. This framework allows for greater collaboration among the partners responsible for health surveillance. We are concerned that there are still only a few agreements on data sharing between Health Canada and the provinces and territories, and no agreement on common standards and nationally reportable diseases.	LIMITED PROGRESS
2.3 Health Canada, in collaboration with the provinces and territories, should improve the timeliness, accuracy, and completeness of disease information.	Health Canada's progress in this area has been inconsistent: • Many of its surveillance systems still lack timely, accurate, and complete disease information. Exceptions include surveillance systems for enteric diseases, influenza, and AIDS.	LIMITED PROGRESS
	• Progress has been made on The Canadian Integrated Public Health Surveillance Project, which is intended to address these concerns. However, it still faces some challenges and will not likely be fully operational for some time.	SATISFACTORY PROGRESS
2.4 Health Canada, in collaboration with other organizations, should take steps to fill gaps in surveillance of chronic disease, such as diabetes and cardiovascular disease.	Health Canada has made significant progress in developing a national diabetes surveillance system. However, the gaps in other chronic disease surveillance continue.	LIMITED PROGRESS

*Possible ratings are completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Follow-Up for an explanation of the ratings.)

NEW ISSUES

2.5 For the most part, diabetes and breast cancer are the only chronic diseases with a national surveillance system. Despite the recognized importance of surveillance for chronic diseases, limited resources have been allocated to this area and health surveillance information is lacking for cardiovascular disease, musculoskeletal disease, cancer (except breast cancer), chronic respiratory disease, mental illness, and injuries. Further, surveillance is also lacking for risk determinants and for impacts of interventions, screening, and treatment on health outcomes.

2.6 Health Canada should identify its health surveillance priorities and ensure that adequate and stable funding is available to develop and maintain the surveillance systems that it identifies as priorities.

Health Canada has responded. Health Canada has agreed to continue working on the recommendations and taking corrective actions as described in its responses, included in the chapter.

Introduction

Health surveillance: Essential for public health activities

2.7 Health surveillance is a core function of public health activities. It begins with the ongoing collection of information on disease, which is then integrated, analyzed, and interpreted. The data these activities produce are disseminated in a variety of formats to those who need the information so they can take appropriate action.

2.8 Information informs decision makers and is crucial to their making the right decisions at the right times. Information obtained through health surveillance is important for understanding the health status of a population. Authorities can use health surveillance information to identify a disease outbreak and respond to it and to prevent disease by educating the public about factors that may put health at risk (that is, risk determinants, such as lack of exercise). Further, the information can be used to monitor the incidence of disease and to help control disease by determining the most effective treatment. Health surveillance information is also needed to develop government health policies and programs, to measure the performance of government activities and evaluate their effectiveness, and finally, to assess the quality and accessibility of health care.

2.9 Provincial, territorial, and municipal governments as well as public health professionals and laboratories are closely involved in health surveillance. As primary providers of public health services, they supply Health Canada with disease information for national health surveillance. Health Canada's role is to provide leadership and support for health surveillance across the country. It is responsible for gaining the collaboration of the various partners in health surveillance, integrating the disease information it receives from them, developing the surveillance systems to analyze and interpret the information, and then disseminating the results. Other partners in health surveillance include Statistics Canada, the Canadian Institute for Health Information, the Canadian Food Inspection Agency, and several organizations outside government.

2.10 Collaboration is critical to national health surveillance, given the many partners it involves. Working together allows for timely information sharing, co-ordinated responses, and effective action.

2.11 The risks that poor health surveillance creates are very real: preventable illnesses may not be prevented, approaches to treating disease may not be as effective as they could be, and government funding may be directed at the wrong health issues. For example, in 1999 we reported on a salmonella outbreak during which the exchange of information was not as timely and collaboration not as effective as they could have been, while the illness spread.

2.12 Health Canada's Population and Public Health Branch is responsible for national health surveillance. The Branch was created in a reorganization of Health Canada in 2000. In addition to health surveillance and disease

control, the Branch is responsible for policies, programs, and systems for disease and injury prevention, health promotion, community action, and the Department's emergency preparedness and response capacity. Its responsibilities include most elements of the former Laboratory Centre for Disease Control and the former Health Promotion and Programs Branch, as well as some responsibilities of the former Health Protection Branch. Our Office reported on the Branch's population health activities (disease and injury prevention, health promotion, and community action) in December 2001.

2.13 The Branch is divided into several centres. Those mainly responsible for surveillance include the Centre for Surveillance Coordination, the Centre for Infectious Disease Prevention and Control, the Centre for Chronic Disease Prevention and Control, the Centre for Healthy Human Development, the Centre for Emergency Preparedness and Response, the National Microbiology Laboratory, and the Laboratory for Food-borne Zoonoses (diseases that animals can transmit to humans through food).

2.14 In 2001–02, the Population and Public Health Branch had a budget of $365 million. That included $66 million for salaries and $13 million for benefits of 1,146 full-time staff equivalents, and $78 million for operating expenses. It also included $208 million for grants and contributions, most of it destined for population health activities rather than health surveillance activities.

Concerns we raised in 1999

2.15 In 1999 we examined the way Health Canada carried out national health surveillance activities and how those activities supported the other components of public health—health assessment, health promotion, disease and injury prevention, and health protection.

2.16 Our report raised a number of concerns about the Department's national health surveillance activities. We concluded that our concerns were significant and called for corrective action in several areas.

2.17 Specifically, we were concerned that there was no mechanism for assigning roles and responsibilities between Health Canada and its provincial and territorial partners. We also identified weaknesses in both the disease information forwarded to Health Canada and the Department's dissemination of surveillance information in its various forms. We noted gaps in surveillance activities in areas where surveillance systems were inadequate. Finally, we were concerned about the way Health Canada had evaluated, measured, and reported the performance of its national health surveillance activities.

Focus of the follow-up

2.18 The objective of this follow-up was to determine the progress made in addressing the observations and recommendations contained in our 1999 Report—Chapter 14, National Health Surveillance: Diseases and Injuries; and Chapter 15, Management of a Food-borne Disease Outbreak. We also

followed up on recommendations made by the Standing Committee on Public Accounts. We looked at the Department's actions and the commitments it had made in response to our audit; and we reviewed the progress it had reported to the Public Accounts Committee. In the last three years, Health Canada has undertaken a number of new initiatives related to national health surveillance, which we also reviewed. Our report presents the results of the areas that were re-audited. Further details about the follow-up's objective, scope, and criteria can be found in About the Follow-Up at the end of the chapter.

Observations and Recommendations

Improving collaboration on national health surveillance

2.19 In 1999 we noted that a survey of public health professionals at the provincial, territorial, and regional levels revealed that participants wanted Health Canada to take a more proactive role in health surveillance. They agreed that strong leadership was needed from Health Canada.

2.20 At that time, we also noted two factors that were compromising Health Canada's ability to conduct national health surveillance:

- There was neither federal public health legislation nor a national framework to link the separate public health activities of the provinces and territories.
- There was no agreement among the various partners on clearly defined roles and responsibilities for collecting and disseminating data and for responding to public health threats.

Progress in developing a national framework

2.21 Each province and territory has its own public health legislation and public health priorities, resulting in 13 separate public health systems. Making progress in this complex environment can be a challenge. Therefore, strong national leadership is needed.

2.22 In 1996, Health Canada recognized that because each province and territory has its own public health legislation, a national framework would be needed if national health surveillance were to succeed. In its response to our 1999 audit report, Health Canada noted that it was reviewing its legislation with a view to updating it so it would better support national health surveillance.

2.23 Our follow-up found that there is still no public health legislation and that the legislative review is still under way. However, Health Canada has made progress in establishing a framework for national health surveillance to ensure collaboration among the partners. It has established a number of federal/provincial/territorial committees to advise and act on issues of national health surveillance (Exhibit 2.1). These committees are a useful way to ensure that all the partners participate. The committees have set goals for themselves and are working toward them.

Exhibit 2.1 Federal/provincial/territorial committees on national health surveillance

Health Surveillance Working Group—provides a pan-Canadian forum that links the federal, provincial, and territorial governments to build a national health surveillance infostructure system. The Working Group reports to the Advisory Committee on Health Infostructure and the Conference of Deputy Ministers of Health. It has three sub-groups:

- **Communicable Disease Surveillance Sub-Group**—to provide leadership and develop a strategy for the co-ordination and integration of communicable disease surveillance systems in Canada.
- **Chronic Non-Communicable Disease Infostructure Sub-Group**—to provide leadership and develop a strategy for the co-ordination and integration of chronic disease surveillance systems in Canada.
- **Injury Surveillance Sub-Group**—to provide advice and recommendations to Health Canada, federal/provincial/territorial stakeholder groups, and other organizations that maintain injury information systems and to support the effort to build and maintain a national injury surveillance infostructure for Canada.

Canadian Public Health Laboratory Forum—to provide leadership in the public health laboratory functions and provide advice on issues related to delivery of services by public health laboratories.

National Health Surveillance Infostructure Project—to develop infostructure systems to address issues and gaps related to national health surveillance.

Canadian Integrated Public Health Surveillance Project Collaborative—to lead in defining, developing, and promoting the Canadian Integrated Public Health Surveillance Project.

2.24 As part of its reorganization in 2000, Health Canada created the Centre for Surveillance Coordination. Its function is to provide leadership on co-ordination issues related to national health surveillance and to support the federal/provincial/territorial committees by carrying out specific tasks for them.

An established approach to national health surveillance is still many years away

2.25 To advance a national framework, the Health Surveillance Working Group has agreed on an approach for improving national health surveillance. For example, it has agreed that developing a national health surveillance "infostructure" system should be a goal of the partners. Subgroups are working to develop specific approaches to improving surveillance systems for communicable disease, chronic disease, and injury. They are identifying gaps in surveillance systems, such as the lack of standards for data, and are developing plans to address these gaps.

2.26 These are comprehensive approaches that the committees believe will address many of the weaknesses in national health surveillance. We are concerned, however, that Health Canada has set no specific timelines for implementing them and so we do not know when the Department expects to have the approaches in place. We were informed that given their comprehensiveness, it will likely take several to many years.

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2.27 Also of concern is that these approaches are being developed largely independent of current surveillance activities. Rather than incremental improvements to current surveillance activities, they involve comprehensive change. In the meantime, many of the same weaknesses and gaps continue in national health surveillance as we observed in 1999.

Lack of agreement on roles and responsibilities

2.28 Clearly defined and agreed-on roles and responsibilities are a key element of successful national health surveillance. They are particularly important in the areas of collecting and disseminating data and responding to public health threats.

2.29 **Lack of agreement on data sharing between Health Canada and the provinces and territories.** Disease information is the property of the provinces and territories. To ensure that this information is shared appropriately and that the *Privacy Act* is not violated, the details of data sharing need to be outlined clearly in written agreements. Agreements on data collection need to cover such details as how the data will be used, who owns the data, what standards will be followed, and how privacy and confidentiality will be protected. Agreements on data dissemination need to cover such details as what information can be published and who can receive it. Finally, each agreement should outline the consequences of not respecting it.

2.30 At present, only a few agreements on data sharing exist (for example, on HIV/AIDS), and no generic agreement has been developed to ensure that all important details are covered. Since much of Health Canada's disease information comes from other partners, any agreements would need to clearly outline the responsibilities of all partners in the sharing of that information.

2.31 **Health Canada slow to develop common standards for data to be shared.** We recommended in 1999 that Health Canada establish common standards and protocols for classifying, collecting, and reporting data on communicable diseases.

2.32 Common or uniform standards and protocols are critical to ensuring that disease information is consistent. Consistency is important because national health surveillance involves integrating information so it can be analyzed on a national basis. Our follow-up found only limited progress on the development of common standards. The Communicable Disease Surveillance Sub-Group has begun developing standards for nationally reportable diseases, immunization information, and vaccine-associated adverse events (bad reactions to a vaccine). Progress has been made on the development of standards for data elements and the core data set (the set of data elements that are common to all diseases—for example, gender, and date of onset of illness). However, only very limited progress has been made on elaborating disease-specific data sets (for example, defining the symptoms of a specific disease) and laboratory standards (such as which lab test to use).

2.33 Once standards have been developed, agreement on them must be reached. We found that there is no national agreement on a mechanism for

maintaining or approving standards on behalf of all the partners. Without this mechanism, Health Canada has no way of ensuring that common standards are respected.

2.34 Still no formal agreement on which diseases should be reported nationally. In 1999 we noted that there was no formal agreement on which communicable diseases would be reportable (notifiable) to Health Canada (those of particular concern, such as tuberculosis and rabies). Nor was there agreement on which of several emerging diseases should be added to the list.

2.35 Our follow-up found that there is still no formal agreement requiring provinces and territories to accept or respect the list of nationally reportable diseases. However, informal agreement exists on a list of reportable diseases. The list was updated in 2000, and work is under way to update it again to include several bioterrorist agents, such as smallpox and anthrax.

2.36 Progress made in agreeing on a co-ordinated response to public health threats. Our 1999 report observed that Health Canada had not defined clearly who was responsible for doing what in the event of an emergency public health threat—for example, controlling diseases at ports of entry, managing outbreaks of food-borne disease, or dealing with an influenza pandemic.

2.37 We found that a number of important improvements in this area have been made over the last three years or are nearing completion. At this writing, a memorandum of understanding (MOU) on controlling diseases at ports of entry was soon to be signed by Health Canada and the Canada Customs and Revenue Agency. This MOU would provide for training front-line customs officers to handle situations that potentially involve the importation of illness. Health Canada and the Canadian Food Inspection Agency have signed a Food-borne Illness Outbreak Response Protocol and an MOU; at this writing, the provincial and territorial governments were being consulted in the hope that they would sign the agreements, too. To prepare for the possibility of an influenza pandemic, Health Canada has contracted privately with a company to ensure that there is an infrastructure to provide enough vaccine to make Canada self-sufficient within the next few years. The Department is negotiating a new MOU with provincial and territorial governments that outlines clearly their roles and responsibilities in the event of an influenza pandemic. The MOU will replace an outdated working agreement.

2.38 In summary, Health Canada has made progress on developing a framework for national health surveillance. However, it has made only limited progress on resolving weaknesses and gaps in national health surveillance activities. For the most part, there is still no agreement on important matters such as data sharing, common standards, and nationally reportable diseases. Strong leadership is needed to ensure that all partners work together to advance these initiatives without delay.

2.39 **Recommendation.** Health Canada should work with the provinces and territories to set specific timelines for implementing a national approach to health surveillance that will ensure that weaknesses and gaps in health surveillance are remedied.

Health Canada's response. A national approach to health surveillance is set out in the Canadian Health Infostructure Health Surveillance Tactical Plan. Health Canada and the provinces and territories are supportive of the directions set out in this Plan. At the first opportunity, Health Canada will discuss with the provinces and territories the setting of time lines under the Plan.

2.40 **Recommendation.** Health Canada should work with provinces and territories to obtain agreement on the sharing of disease information, including agreement on data collection, data dissemination, data standards, and the list of diseases that should be reported nationally. Further, it should work with the provinces and territories to create a mechanism for maintaining and accepting data standards.

Health Canada's response. Health Canada will continue its work with the provinces and territories to obtain further agreements on the sharing of disease information, including agreement on data collection, data dissemination, data standards, and the list of diseases that should be reported nationally. Health Canada will also continue its work with the provinces and territories to create a mechanism for maintaining and accepting data standards.

Priority setting and business planning

2.41 In 1999–2000, Health Canada prepared a draft business plan for its health surveillance activities (at that time delivered by the Laboratory Centre for Disease Control). The development of this plan was a comprehensive process and included consultation with leading medical and technical public health professionals. Out of this process, Health Canada set its priorities. Although this plan was never finalized, it was presented to the Deputy Minister of Health Canada, the federal/provincial/territorial Public Health Working Group, and the Prime Minister's Office.

2.42 Shortly thereafter, in 2000, Health Canada reorganized. The Population and Public Health Branch (which then became responsible for health surveillance) began a new priority-setting process. Our Office reported on this process in our December 2001 Report, Chapter 9. In that report, we noted that first steps had been taken to set priorities, including a program review exercise. During our follow-up, we determined that Health Canada had never completed that exercise.

2.43 This means that the Department has still not formally established priorities among its health surveillance activities.

Weaknesses in existing disease surveillance systems

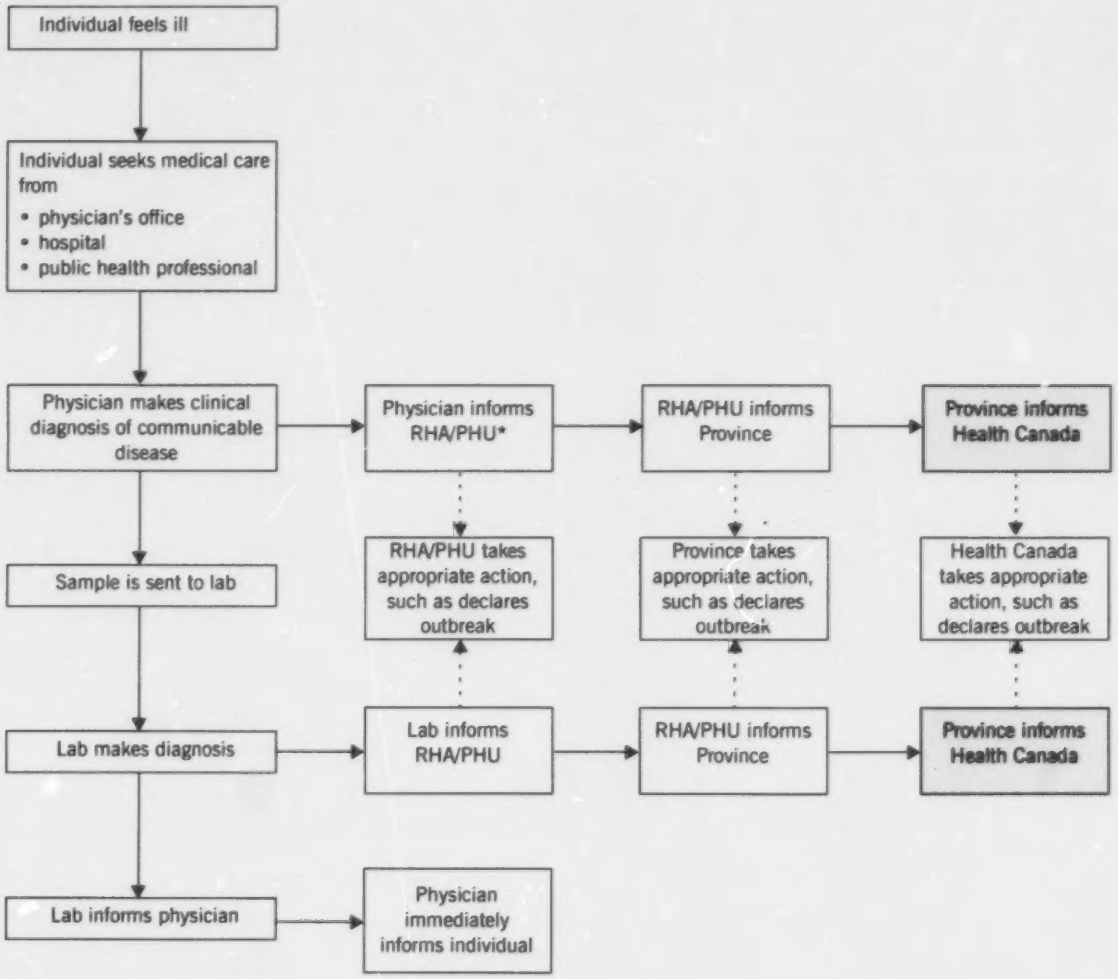
2.44 Disease surveillance systems are tools that enable Health Canada to track and forecast diseases and injuries, risk determinants, and health outcomes. Such systems entail the ongoing collection of disease information; the integration, analysis, and interpretation of that information to create

surveillance products; and the dissemination of those products to governments and public health professionals. Surveillance products can range from data such as the national incidence of a disease in a given week to a comprehensive annual report that includes incidence, mortality, risk determinants, and health care costs for a particular disease.

Communicable disease surveillance: Improvement has been inconsistent

2.45 Information on communicable (infectious) diseases comes from a number of sources, including physicians, hospitals, public health workers in regional health authorities (RHA) or public health units (PHU), and public and private laboratories. Exhibit 2.2 illustrates how information should flow to Health Canada.

Exhibit 2.2 How information on communicable disease should reach Health Canada


Individual feels ill
Individual seeks medical care from
• physician's office
• hospital
• public health professional
Physician makes clinical diagnosis of communicable disease
Physician informs RHA/PHU*
RHA/PHU informs Province
Province informs Health Canada
Sample is sent to lab
RHA/PHU takes appropriate action, such as declares outbreak
Province takes appropriate action, such as declares outbreak
Health Canada takes appropriate action, such as declares outbreak
Lab makes diagnosis
Lab informs RHA/PHU
RHA/PHU informs Province
Province informs Health Canada
Lab informs physician
Physician immediately informs individual

*RHA—Regional health authorities
PHU—Public health units

2.46 Because of the number of sources of disease information (which are all outside Health Canada) and the number of transfers of that information before it reaches Health Canada, it is a challenge for the Department to determine that the information is timely, accurate, and complete. Any breakdown in the flow of information affects the information Health Canada receives, which in turn affects its ability to take action.

2.47 Health Canada also needs to ensure that the surveillance products it disseminates are timely and contain accurate and complete information if they are to be of value. Any deficiencies in the information it receives will severely impair the effectiveness of its surveillance products.

2.48 In 1999 we reviewed a number of surveillance systems for specific communicable diseases. We raised several concerns about the timeliness and quality of communicable disease information collected by Health Canada and disseminated as surveillance products. The concerns we had about four of these systems—the Notifiable Diseases Reporting System and the AIDS, influenza, and enteric diseases systems—are summarized in Exhibit 2.3.

2.49 Since 1999, the AIDS, influenza, and enteric diseases systems have received additional funding, directed by the Treasury Board. Our 2002 follow-up of these systems found that Health Canada has improved them. The Notifiable Diseases Reporting System did not receive additional funding. We found that improvements to this system were limited. In all four systems we found more timely dissemination of surveillance products, although the

Exhibit 2.3 Progress in surveillance of communicable diseases

Surveillance system	Our observations in 1999	Follow-up observations in 2002
Notifiable Diseases Reporting System	• Underreporting by physicians • Delays in receiving data • Data received from provinces with different frequency, in different formats	• Limited improvement since 1999 • Monthly reporting about four months behind (some provinces missing); quarterly reporting of preliminary data; annual report for 1999 the most recent
AIDS	• Underreporting by physicians • Delays in receiving data • Data incomplete • Data not sent by all provinces • Timely dissemination	• Improvement: field surveillance officers in provinces and some formal data-sharing agreements • Annual report for 2001 the most recent
Influenza	• Sentinel physician reporting incomplete • Dissemination problematic	• Improvement in four reporting systems—sentinel physician; laboratory; provincial activity; and international • Weekly reporting, available the following week
Enteric (gastro-intestinal) diseases	• Delays in receiving data	• Improvement in three reporting systems—laboratory; outbreak; genetic fingerprint • Weekly laboratory reporting, available the following week; real-time reporting available for outbreak and genetic fingerprint

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quality of the products is still limited by the quality of the disease information on which they are based. The progress we found in these four systems is also summarized in Exhibit 2.3.

2.50 Exhibit 2.4 describes two other surveillance systems we reviewed—the disease-specific surveillance systems for the incidence and outbreak of meningococcal infection and for the incidence of vaccine-associated adverse events. The exhibit also discusses our concerns about the timeliness and quality of the disease information collected.

2.51 Health Canada's challenges in collecting communicable disease information continue. They include

- **Timeliness.** Data sources submit disease information according to their own schedules—for example, immediately, daily, weekly, or monthly.
- **Accuracy.** Data sources submit disease information in their own ways—for example, some give the date of onset as the date of diagnosis and others give the date of first symptom.
- **Completeness.** Data sources may submit no information or only partial information.

Steps to improve communicable disease information: The Canadian Integrated Public Health Surveillance Project

2.52 Health Canada recognizes the weaknesses in the disease information it collects, and it has developed the Canadian Integrated Public Health Surveillance Project to address some of them. This project comprises a group of integrated computer and database applications that will allow public health professionals in the provinces to collect and forward information on communicable diseases to Health Canada. By standardizing reporting, it will make disease information more

- timely, with case-by-case electronic and real-time data;
- accurate, with common modules and standards; and
- complete, with the potential to be used at all public health offices and laboratories.

2.53 The project is managed by a collaborative group of federal and provincial representatives. It is really two information management systems. The first, the Public Health Information System, manages epidemiological/clinical data. The second, the Laboratory Data Management System, manages laboratory data. Health Canada has made satisfactory progress on this project. The Public Health Information System is operational in British Columbia and is soon to be piloted in several regional health authorities or public health units in seven provinces and territories. The Laboratory Data Management System is being used in two federal laboratories.

2.54 This project has the potential to improve the quality of surveillance information. Our concerns remain, however, because full implementation is still some time away, the disease information in current systems is still inadequate, and limited effort has been made to find an interim solution. We have identified several matters that need to be resolved before these systems

can succeed. First, compatibility of provincial systems with the national system must be assured. Second, data standards have yet to be agreed on. Third, obtaining agreement on data sharing, data ownership, and privacy protection remains a challenge. Finally, the project will not fully address concerns about the completeness of the data. The impact of the two systems on the timeliness and quality of communicable disease information may not be evident for some time.

Exhibit 2.4 Meningococcal disease and vaccine-associated adverse events

Meningococcal disease is serious and sometimes fatal. About one in ten persons who develop the disease may die and one in ten who recover will suffer some long-term effects, such as deafness. The number of cases of meningococcal disease goes up and down in regular cycles, with local and regional outbreaks occurring about once every 10 to 15 years. Although the disease can occur at any age, the highest risk is among children under a year old, with the next-highest risk among teenagers aged 15 to 19 years.

There are effective antibiotics for the treatment of meningococcal disease. Vaccines against several meningococci types are available and may be used in an outbreak situation to provide protection.

Meningococcal disease is a reportable disease and is therefore reported through the Notifiable Disease Reporting System. Health Canada also has an enhanced (disease-specific) surveillance system for meningococcal disease. Because the disease is preventable with a vaccine, any adverse events (bad reactions) following vaccination should be reported through the surveillance system for vaccine-associated adverse events.

The enhanced system is intended to receive case-by-case disease information (confirmed cases, with case information linked to lab data) and outbreak information electronically from the provinces on a real-time basis. However, reporting by the provinces is not always timely and complete. Standards for the required information have not been developed. Case information for meningococcal disease is sometimes submitted independent of the lab data. Matching at the federal level can be difficult, and unmatched data have less value. During an outbreak, the quality of data generally improves as provinces focus more on meningococcal disease. However, during an outbreak the data often arrive through informal channels, such as emergency phone calls or e-mails, rather than the formal surveillance system. As a result, the communication of timely, accurate, and complete information on meningococcal disease is a concern. The most recent report on meningococcal disease was published in 2000 and relied on data from 1997 and 1998.

One means of dealing with a meningococcal outbreak is to vaccinate vulnerable population groups. With every vaccination there is a risk of an adverse event. Health Canada has two surveillance systems that provide some information on vaccine-associated adverse events. The systems are of limited value in collecting timely, accurate, and complete information on vaccine-associated adverse events from meningococcal vaccination. The first is a network of 12 pediatric hospitals that provide information on patients who may be suffering from a serious reaction to the vaccine. The system's value is limited because it would not capture an adverse event unless the individual went to a pediatric hospital, and people in one of the most vulnerable age groups—15 to 19—are not likely to be patients in a pediatric hospital. The second system collects information from public health professionals on a standard form; it is a voluntary system. Health Canada recognizes the limitations: a voluntary system is unlikely to provide complete information. However, it believes that the more serious the adverse event, the more likely it is to be reported. The last annual report on adverse events was published in 1997.

can succeed. First, compatibility of provincial systems with the national system must be assured. Second, data standards have yet to be agreed on. Third, obtaining agreement on data sharing, data ownership, and privacy protection remains a challenge. Finally, the project will not fully address concerns about the completeness of the data. The impact of the two systems on the timeliness and quality of communicable disease information may not be evident for some time.

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2.55 In summary, Health Canada has made progress in enhancing the surveillance systems for which it received directed funding from the Treasury Board. It has made only limited progress on the others. The Canadian Integrated Public Health Surveillance Project has the potential to address some weaknesses, but it still faces some challenges. In the meantime, current disease information remains inadequate.

2.56 **Recommendation.** Health Canada should enhance its current surveillance of communicable diseases while it continues to advance the Canadian Integrated Public Health Surveillance Project.

Health Canada's response. Health Canada will continue to enhance current surveillance of communicable diseases, with particular emphasis on specific diseases such as HIV, enteric diseases, sexually transmitted infections, blood-borne pathogens, and vaccine-preventable diseases. The Department will continue to advance the Canadian Integrated Public Health Surveillance Project.

Chronic disease surveillance: Limited progress

2.57 Chronic disease information is collected from a number of sources, including disease registries, such as those for cancer; administrative data such as hospital records and provincial billing records for health services; morbidity and mortality data maintained by Statistics Canada; and health surveys such as the National Population Health Survey. This information is not sent automatically to Health Canada, although it is available to the Department for its surveillance activities.

2.58 Once the information is collected, Health Canada has a number of surveillance systems that integrate, analyze, and interpret disease information and create and disseminate surveillance products based on that information.

2.59 In 1999 we noted problems in the disease information collected for two of several cancer surveillance systems, the Childhood Cancer Treatment and Outcome Surveillance System and the National Enhanced Cancer Surveillance System. The first system is part of a broader surveillance system, the Canadian Childhood Cancer Surveillance and Control Program. We found that the Treatment and Outcome system had incomplete data on youths between 15 and 19 years of age and that no results of any analysis had been reported. Our follow-up determined that no progress had been made toward filling the information gaps, but a report on the results of its analysis of the data collected from the Childhood Cancer Treatment and Outcome Surveillance System is scheduled to be published. Also of concern is the very limited activity in surveillance for the late effects, etiology investigation, and tissue bank systems—the other systems in the Childhood Cancer Program.

2.60 In 1999, it was determined that there were gaps in the environmental data collected by National Enhanced Cancer Surveillance System. Our 2002 follow-up found that the information gaps had not yet been filled and that more current information has not been collected. Health Canada has published a number of reports on the results of its analysis.

2.61 **Recommendation.** Health Canada should collect the disease information needed to provide a complete and timely picture of cancer in Canada.

Health Canada's response. Health Canada's current picture of cancer in Canada includes cancer incidence and mortality data. Health Canada needs more concrete information on risk factors, severity at the time of diagnosis, and treatment data. The Department will continue its work with the provinces and territories to get such concrete information.

Gaps in national health surveillance activities

2.62 Most of Health Canada's existing disease surveillance systems focus on the incidence of disease. However, there are opportunities for collecting and analyzing information on disease beyond its incidence.

2.63 As an individual moves from health to disease to health outcome, that individual will interact with the health care system many times (Exhibit 2.5). Each time, disease information can be collected for surveillance activities (Exhibit 2.6).

2.64 Gaps in surveillance exist because there may be no surveillance system at all or because an existing surveillance system may focus largely on the incidence of disease and not on other important areas. Those areas can include risk determinants and the impacts of interventions, screening, and treatment on health outcomes.

2.65 In its 1999–2000 draft business plan, Health Canada recognized a number of gaps in surveillance, particularly surveillance of chronic diseases. It also demonstrated the significance of chronic diseases to the health of Canadians, as measured by the projected cost of these diseases for 1998 (Exhibit 2.7).

2.66 In 1999 we noted that national surveillance activity for cardiovascular disease was inadequate—specifically, surveillance of incidence, risk determinants, intervention, and treatment. Our report acknowledged that Health Canada was working to develop a national system that it expected would be operating fully in 2003. We also noted a gap in national surveillance of diabetes, but a national system was to be operating fully in 2000.

2.67 Our follow-up found that there are still some significant gaps in surveillance:

- Cardiovascular disease surveillance. Health Canada has done little work on developing a national system for surveillance of cardiovascular disease, a disease projected to cost Canadians $21 billion in 1998. During our 1999 audit, work had begun on developing a Canadian Heart Disease and Stroke Surveillance System Network. The Network made some initial progress but after a business plan was developed, the funding for the Network ended. Health Canada's present activities in this area are directed largely at publishing a biannual report on heart disease and stroke that provides only very limited information on the disease. The Chronic Non-Communicable Disease Infostructure Sub-Group is currently contributing to a study on the feasibility of extending the diabetes surveillance system to include cardiovascular disease.

Exhibit 2.5 Public health services and disease continuum

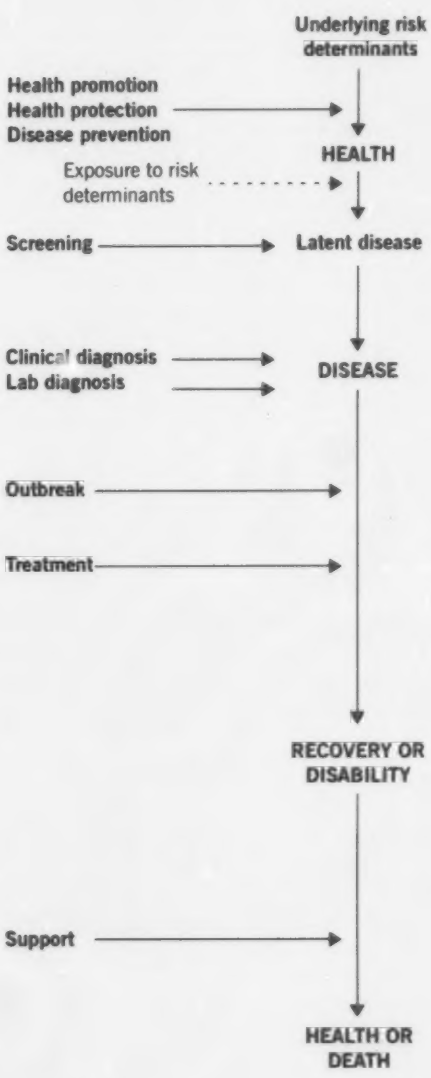

Exhibit 2.6 Opportunities in the delivery of public health services for surveillance

Opportunities exist in the delivery of health care for surveillance systems to monitor the following:

- Risk determinants (behaviour, environment, age, gender, social support, etc.)—to identify the factors that influence disease.
- Health promotion, health protection, disease prevention—to evaluate the effectiveness of these interventions.
- Screening—to evaluate the effectiveness and coverage of screening activities.
- Incidence—to quantify how many new cases of a particular disease have been identified in Canadians during a given period.
- Prevalence—to quantify the total number of cases of a particular disease in the Canadian population during a given period.
- Outbreak—to identify an outbreak of a communicable disease and to plan a response to the outbreak.
- Treatment—to evaluate the effectiveness of a treatment and the economic burden of the treatment, for example,
  - Drug—to evaluate the effectiveness of drugs and adverse reactions to drugs, and to identify drug resistance
  - Surgical—to evaluate the effectiveness of surgical practices and to develop best practices
  - Vaccination—to evaluate the effectiveness of vaccination strategies, longevity of protection, and adverse reactions to vaccines.
  - Rehabilitation—to evaluate the effectiveness of rehabilitation options and to develop best practices.
- Support (hospital, home care, and palliative care)—to evaluate the effectiveness of support and its economic burden and to measure accessibility to health care.
- Health—to measure the health of Canadians.

Exhibit 2.7 Projected costs of selected diseases for 1998

Diagnostic category	($ billions)		
	Direct cost	Indirect cost	Total cost
Cardiovascular (i.e., heart disease and stroke)	7.3	13.7	21
Musculoskeletal (i.e., arthritis)	2.5	15.5	18
Injuries	3.1	10.9	14
Cancer	3.2	9.8	13
Chronic Respiratory (i.e., asthma)	3.7	8.3	12
Mental Illness	5.1	2.9	8

Source: Health Canada Business Plan, 1999-2000

- **Diabetes surveillance.** Health Canada has made significant progress on developing a national diabetes surveillance system (Exhibit 2.8).
- **Other important chronic diseases.** There are still a number of key health issues for which surveillance is inadequate. These include chronic diseases such as musculoskeletal disease (for example, arthritis), cancer (except breast cancer), chronic respiratory disease (for example, asthma), and mental illness (for example, depression). These four diseases had projected costs of about $50 billion in 1998.
- **Risk determinant and health outcome surveillance.** There are many gaps in the surveillance of risk determinants and the impacts of interventions, screening, and treatment on health outcomes. For example, while the development of a surveillance system for breast cancer screening is progressing, no surveillance system currently collects information on patient outcomes after various breast cancer treatments. As a result, physicians and breast cancer patients have only limited information on treatment options (Exhibit 2.9). Similarly, the diabetes surveillance system will be able to provide information on the incidence, prevalence, and associated health problems of diabetes but not on risk determinants, intervention, treatment, or incidence in children under 19 years of age. An inventory of opportunities for surveillance systems for notifiable diseases, AIDS, cardiovascular disease, and cancer (excluding breast cancer) is included in Exhibit 2.10.

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Exhibit 2.8 National surveillance system for diabetes

Diabetes is the seventh leading cause of death in Canada. It is estimated that 33 percent of persons with diabetes do not know they have it. If left untreated or managed improperly, diabetes can slowly damage the body. This creates complications such as heart disease, blindness, and kidney disease. It is also estimated that 90 percent of all persons with diabetes suffer from type II diabetes, which can be prevented or delayed by modifying two known risk determinants—obesity and physical inactivity.

In 1999, the federal governme[illegible]developed the Canadian Diabetes Strategy, with four main components. One compon[illegible]t was the development of a national diabetes surveillance system, and it has seen significant progress since then. All 13 provinces and territories are signatories to a memorandum of understanding that outlines the participation and responsibilities of all partners.

The data for the system are administrative data, such as physicians' billings and hospital discharges. Each year, Health Canada receives these data from the provinces, separated between cases that might indicate diabetes and cases that do not. The data are used to determine the prevalence of diabetes.

Health Canada intends to develop mathematical models that can be applied to the data to correct for false positives. This would allow it to estimate the incidence of the disease.

In the future, the Department will be able to analyze administrative data to identify other health problems (complications) associated with diabetes.

So far, data on prevalence, incidence, and complications from 1995 to 2000 have been collected from nine provinces and territories. The information on prevalence is being analyzed and the Department plans to issue its first annual report in 2002.

Exhibit 2.9 Surveillance system for breast cancer treatment

Breast cancer is the most common cancer among women in Canada. It is diagnosed in more than 19,000 Canadians every year. A study by the National Cancer Institute of Canada suggested that the direct costs of breast cancer totalled $7 billion in 1990. That is just one third of the estimated indirect costs.

In 1993 the Canadian Breast Cancer Initiative was launched, with a financial commitment of $25 million for five years. In 1998 the program was renewed to 2003, with total funding of $35 million or $7 million annually. The goal of the initiative is to encourage and support research related to the prevention, treatment, and control of breast cancer. The initiative has five components, one of which is surveillance and monitoring of breast cancer. This component is divided into three sub-components: screening surveillance; risk factor surveillance; and treatment and palliative care surveillance.

It appears that most effort has been directed at surveillance of breast cancer screening. A system for collecting data from organized screening programs already exists and is soon to be extended to include non-organized screening programs. Health Canada has undertaken only limited activities to develop a breast cancer treatment surveillance system; at present there is no such system.

Surveillance information on breast cancer treatment would be of great value to physicians and breast cancer patients. For example, long-term effects of treatment could be monitored and used to assist physicians and patients in decision making. This represents a missed opportunity.

- **Injury surveillance.** The national system for surveillance of injuries to Canadians, which had an estimated annual cost of $14 billion in 1998, is incomplete. At present, injury surveillance is largely limited to children. The Injury Surveillance Sub-Group has prepared an inventory of data sources and surveillance activities on injuries. It has also begun an injury surveillance pilot project with the British Columbia Injury Research and Prevention Unit, which captures injury data for all ages directly from 10 hospital emergency departments in British Columbia.

2.68 In summary, a significant number of gaps remain in the surveillance of chronic diseases and injuries. Health Canada's efforts are limited largely to surveillance of diabetes and breast cancer. Consequently, it has only limited surveillance information on many of the leading causes of death in Canada.

2.69 **Recommendation.** Health Canada, in collaboration with other organizations, should take steps to fill identified gaps in surveillance by ensuring the timely development of national surveillance systems for chronic diseases.

Health Canada's response. Health Canada has surveillance systems for chronic disease at various levels of maturity and, in collaboration with provinces and territories and others, will continue its work toward addressing specific gaps such as cardiovascular disease, chronic respiratory disease, and musculoskeletal disease.

Exhibit 2.10 Opportunities for surveillance systems—Four diseases

Surveillance opportunity	Notifiable diseases	AIDS	Cardio-vascular	Cancer (system excludes breast cancer)
Risk determinants	N/A	●	●	●
Health promotion, health protection, disease prevention	○	○	○	○
Screening	N/A	N/A	○	○
Incidence	●	●	○	●
Prevalence	○	●	○	●
Outbreak	●	N/A	N/A	N/A
Treatment	○	○	○	○
Support	○	○	○	○
Health	○	○	○	○

● Surveillance system exists but has weaknesses, as discussed in the chapter.

○ There is no surveillance system, or surveillance is limited.

N/A Not applicable.

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Prevalence	○	●	○	●
Outbreak	●	N/A	N/A	N/A
Treatment	○	○	○	○
Support	○	○	○	○
Health	○	○	○	○

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○ There is no surveillance system, or surveillance is limited.

N/A Not applicable.

Surveillance issues that need to be resolved

2.70 As we have noted, Health Canada has made limited progress on improving national health surveillance. During our follow-up we identified several factors that have impeded or prevented improvement.

2.71 Many of the factors within Health Canada's control are financial. The centres that conduct surveillance activities receive funding for salaries, operations and maintenance, and grants and contributions. This funding, which represents the centres' financial capacity to deliver programs, comes from three streams. The first stream is referred to as targeted money, funds that the Treasury Board has approved for specific initiatives, mainly within the last five years. As part of obtaining the approval, the Department agrees to achieve certain goals. The Centre for Infectious Disease Prevention and Control has received targeted funds for blood-borne pathogens, enteric diseases (gastro-intestinal illness), influenza pandemic, HIV/AIDS, and hepatitis C. The Centre for Chronic Disease Prevention and Control has received targeted funds for diabetes and breast cancer.

2.72 The second stream of funding is referred to as A-base money. It is the funding that Health Canada allocates to the centres for programs that do not have specifically targeted funding. This stream represents the only discretionary funding available to the centres.

2.73 The third stream is the annual reallocation of resources within Health Canada to offset funding pressures on the Department. This exercise, carried out by the Department's Resource Allocation Committee, is discussed in more detail in paragraph 2.81.

2.74 Funding in 2001–02 to three key centres for operations and maintenance of all their activities is outlined in Exhibit 2.11 (The funding shown includes surveillance activities as well as the other activities of the centres.)

Exhibit 2.11 Operations and maintenance funding in 2001–02 (at 1 April 2001)

	($ '000)		
Program	**Centre for Infectious Diseases Prevention and Control**	**Centre for Chronic Diseases Prevention and Control**	**Centre for Surveillance Coordination**
Targeted funds	23,500	7,900	900
A-base	3,850	1,050	300
Departmental reallocation	0	0	0
Total funding before levies	27,350	8,950	1,200
Levied amounts (deducted)	(4,200)	(1,500)	(200)
Total after levies	23,150	7,450	1,000

Surveillance issues that need to be resolved

2.70 As we have noted, Health Canada has made limited progress on improving national health surveillance. During our follow-up we identified several factors that have impeded or prevented improvement.

2.71 Many of the factors within Health Canada's control are financial. The centres that conduct surveillance activities receive funding for salaries, operations and maintenance, and grants and contributions. This funding, which represents the centres' financial capacity to deliver programs, comes from three streams. The first stream is referred to as targeted money, funds that the Treasury Board has approved for specific initiatives, mainly within the last five years. As part of obtaining the approval, the Department agrees to achieve certain goals. The Centre for Infectious Disease Prevention and Control has received targeted funds for blood-borne pathogens, enteric diseases (gastro-intestinal illness), influenza pandemic, HIV/AIDS, and hepatitis C. The Centre for Chronic Disease Prevention and Control has received targeted funds for diabetes and breast cancer.

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Lack of financial capacity to establish chronic disease surveillance systems

2.75 Health Canada's 1999–2000 draft business plan also recognized that the Department lacked the financial capacity to fill the gaps in disease surveillance. It recommended that resources be directed to

- maintain and extend infectious disease activities, where required; and
- extend the scope of activities for chronic diseases.

2.76 However, our follow-up found that the recommendations in the draft business plan had not been implemented. We were informed that financial capacity remains a concern in 2002. In 2001–02 the Centre for Chronic Disease Prevention and Control received $5 million for diabetes ($1 million of it for surveillance activities); $2.6 million for breast cancer ($0.6 million for surveillance activities); $300,000 for biotechnology (none of it for surveillance activities); and $1.05 million in A-base funding ($0.6 million for surveillance activities).

2.77 The $600,000 in A-base funding is all that is available for all chronic diseases except diabetes and breast cancer—that is, cardiovascular disease, other forms of cancer, musculoskeletal disease, chronic respiratory disease, and mental illness.

Lack of financial capacity to maintain chronic disease surveillance systems

2.78 The Childhood Cancer Treatment and Outcome Surveillance System and the National Enhanced Cancer Surveillance System both received targeted funding for their development. Once they were established, targeted funding ended and an amount to maintain the systems was included in the A-base. Over time, however, the amount in the A-base has eroded.

2.79 The Brighter Futures–Child Development Initiative, for example, targeted funds to the development of the Childhood Cancer Treatment and Outcome Surveillance System for five years. When the Child Development Initiative ended, funding of $1 million to keep the surveillance system operating was added to the A-base. However, the A-base funding has declined consistently (Exhibit 2.12).

2.80 The Population and Public Health Branch has reported that this funding is inadequate. In 2001–02, the Branch identified this surveillance system as one of several surveillance systems that were an unfunded, high-priority project of the Centre for Chronic Disease Prevention and Control. The Branch asked the Department's Resource Allocation Committee for additional funding of $420,000 to operate this system. However, the Centre received no additional funding and had to manage the system within its A-base resources, which we have noted totalled $600,000 for all chronic diseases except diabetes and breast cancer.

Erosion of financial capacity

2.81 Health Canada engages each year in an internal exercise of resource reallocation, managed by its Resource Allocation Committee. The Committee collects money by charging levies to the funds allocated to each

branch of the Department. Inadequately funded activities of all the branches are identified, and those with highest priority are allocated additional funds from the money collected through the levies. The levies charged to the Population and Public Health Branch are collected from the operations and maintenance funding for each of the Branch's centres.

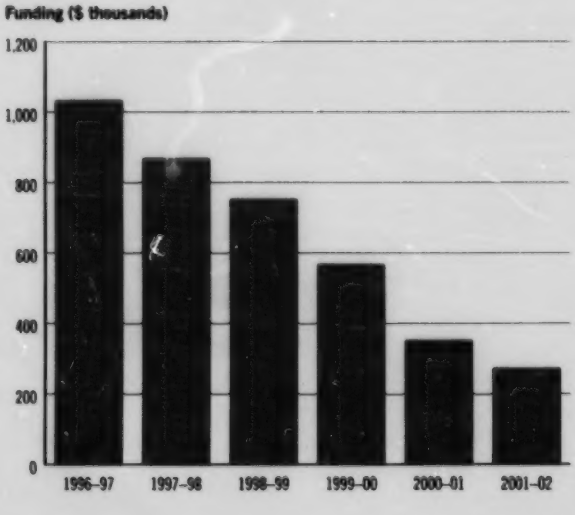
2.82 Other levies to fund various initiatives of the Department are also collected from the centres. Our analysis of resources allocated to each centre determined that the levies charged to the Branch for 2001–02, and then collected from each centre as a percentage of its operations and maintenance funding, were roughly equivalent to

- 15 percent from the Centre for Infectious Disease Prevention and Control,
- 17 percent from the Centre for Chronic Disease Prevention and Control, and
- 17 percent from the Centre for Surveillance Coordination.

The three centres paid a total of almost $5.9 million in levies (Exhibit 2.11), taken from both the targeted funds intended for specific activities and the A-base funds, which are discretionary. The funds were reallocated to other activities within Health Canada, which means they are supporting activities that are not the ones to which the Treasury Board directed the support.

2.83 In 2001–02, the three centres also identified unfunded activities of about $7 million. The Branch requested additional funding for these activities from the Resource Allocation Committee. However, the Committee denied the requests and provided no additional funds. The collection of levies, combined with the denial of requests for funding, has eroded the centres' ability to carry out their surveillance activities.

Exhibit 2.12 A-base funding for Childhood Cancer Treatment and Outcome Surveillance, 1996–2002



Priorities need to be established and supported with funding

2.84 A great many diseases affect Canadians; there are many opportunities for health surveillance. It is clear that not all of the information on diseases can be collected and analyzed.

2.85 It is essential that Health Canada determine its priorities for national health surveillance activities relative to the other activities in the Department. As well, priorities among the various health surveillance activities must be clearly established. This means choosing which key health issues will be surveyed—for example, outbreaks of reportable (notifiable) diseases or interventions for cardiovascular disease. Finally, it is important that Health Canada direct enough resources to those priorities to develop surveillance systems and maintain them.

2.86 As already noted, Health Canada did set priorities for health surveillance activities in 1999–2000. However, those priorities were not supported by funding. And we have already noted that more recent attempts to set priorities have not been completed.

2.87 Health Canada has made only a limited commitment of funding to the centres that conduct national health surveillance. We determined that around 86 percent of the operations and maintenance funding received by the Centre for Infectious Disease Prevention and Control is targeted funding. And 89 percent received by the Centre for Chronic Disease Prevention and Control is targeted. This means that most of the centres' activities are supported by funding directed to the centres by the Treasury Board. Of the funds the two centres receive for their activities, only 14 percent and 11 percent, respectively, come from Health Canada.

2.88 These financial capacity issues create a number of problems for program officials. Funding is variable, the A-base is eroded, and targeted funds are redirected, although the centres remain responsible for delivering adequate national health surveillance.

2.89 **Recommendation.** Health Canada should identify its health surveillance priorities and ensure that adequate and stable funding is available to develop and maintain the surveillance systems that it identifies as priorities.

Health Canada's response. For Health Canada, health surveillance activity is of significant importance. It is a constant and important item for analysis and evaluation at the time of the annual setting of departmental priorities, and it will remain so in the future.

Keeping Canadians safe: Food-borne disease and blood-borne pathogens

2.90 In response to blood and food crises, the Treasury Board directed specific funds to these program areas so that surveillance systems could be improved. We assessed Health Canada's progress in improving the surveillance systems for food-borne disease and blood-borne pathogens.

National surveillance of enteric diseases

2.91 Since 1999, the Department has made progress on developing systems for national surveillance of enteric diseases. Enteric diseases cause gastrointestinal illness and are usually transmitted in food and water. Health Canada has undertaken five major initiatives to improve its surveillance systems:

- **National Enteric Surveillance Program.** A system that collects and analyzes all positive laboratory samples from 10 provincial laboratories. The results are compared against a historical baseline to detect any unusual increase in the incidence of pathogens.
- **Canadian Enteric Outbreak Surveillance Centre.** Two linked Web-based applications that allow information on outbreaks to be shared in confidence among regional, provincial/territorial, and federal public health professionals on a real-time basis once they are posted on the Web.
- **PulseNet North.** A laboratory outbreak identification system that allows information on pathogens to be exchanged in real time. It is linked with the provincial labs in all provinces in Canada and with a similar system in the United States (PulseNet), allowing information sharing across North America.
- **National Studies on Acute Gastrointestinal Illness.** A collection of studies to supplement existing surveillance activities, for example, studies to determine the underreporting of gastrointestinal illness and identify the risk determinants associated with gastrointestinal illness in Canada.
- **National Enteric Surveillance Program Stakeholder Committee.** A federal/provincial/territorial committee to advise on and discuss issues related to national surveillance of enteric diseases.

2.92 The National Enteric Surveillance Program and PulseNet North have been implemented. The Canadian Enteric Outbreak Surveillance Centre finished its pilot phase and is being rolled out in Ontario in 2002. The other initiatives are still quite new but appear promising. Health Canada has also identified areas that need more work, and it plans to make the necessary improvements.

National surveillance of blood-borne pathogens

2.93 In 1996, while the Krever Commission was still finalizing its report on blood safety, the Treasury Board approved funding to strengthen Health Canada's Blood Safety Program. In 1998, after the Commission issued its report, the Treasury Board approved additional funding for the Program. A portion of the funding was to be used to develop the capacity to create a

blood surveillance system. The Department committed to have such a system in place by 2003.

2.94 Health Canada has made progress on developing a national system for the surveillance of blood-borne pathogens. It initiated the Transfusion-Transmitted Injury pilot surveillance system in 1998, modelled on the Quebec system that was already being developed. The Quebec system is based on a network of transfusion safety officers who collect data from hospitals that have a significant level of transfusion activity. The pilot started with Quebec and British Columbia; Nova Scotia and Prince Edward Island were added in 2000 and they submitted data in 2002. Ontario and Manitoba joined in 2002.

2.95 During our follow-up, however, we became aware of issues yet to be resolved that could delay the implementation of the National Transfusion-Transmitted Injury surveillance system. Specifically, we are concerned that Health Canada has not made adequate progress toward assuring that timely, accurate, and complete information from all provinces will be available in 2003. Nor can it be sure that provincial capacity is adequate and can be maintained to provide the information needed for a sustainable national system.

2.96 We will continue to monitor the progress of this surveillance system.

Measuring and reporting performance

2.97 In 1999 we noted that Health Canada had completed few evaluations and had no formal plan to evaluate surveillance systems. We also noted that the framework for measuring performance and the development of performance indicators were incomplete. Finally, we noted that the Department was reporting only limited information to Parliament.

2.98 During our 2002 follow-up, we noted that the Departmental Program Evaluation Division was working on evaluations of the Canadian Strategy on HIV/AIDS and Health Canada's Blood Safety Program. The Population and Public Health Branch has also evaluated a few surveillance systems. This is progress; but given that three years have passed, it is too slow.

2.99 The Department is still developing its performance measures. They have not been approved by senior management, nor have they been distributed widely in the Department.

2.100 Finally, reporting to Parliament remains inadequate. It is limited largely to information on activities and outputs. It does not include information on issues such as the value of surveillance information to support evidence-based decisions.

2.101 **Recommendation.** Health Canada should strengthen its evaluation, performance measurement, and reporting of results of its health surveillance activities.

Health Canada's response. The Department has strengthened its evaluation and performance measurement of health surveillance. Examples include the public release of the health indicators of First Nations health status and the enhanced use of performance information in the departmental performance report. In the performance report, performance expectations are made clear

and concrete, and in the vast majority of cases, key results are reported against expectations. The reliability of performance information is supported by facts, and the use of performance information is demonstrated. Progress will continue to be made in the future.

Standing Committee on Public Accounts

2.102 On 2 March 2000, the Standing Committee on Public Accounts invited our Office and Health Canada to a hearing on Chapter 14 of our September 1999 Report. In May 2000, the Committee released a report that included five recommendations.

2.103 The recommendations focussed on two themes. Four recommended improvements in reporting to Parliament on specific activities (implementation of the Network for Health Surveillance, results and outcomes of the Network, performance measurement and risk assessment, and implementation of the recommendations in our Report). The fifth recommended the development of tools to assist in evaluation, performance measurement, and risk assessment.

2.104 We found that Health Canada has reported some information about the activities of the Network for Health Surveillance. It provided information on important issues such as strategic plans, timelines, and budgets, but the progress it discussed was not measured against those plans, timelines, and budgets. As already noted, reporting on performance measurement and risk assessment remains limited, and only a few evaluations have been completed. The Department provided a status report in 2000 on its implementation of our recommendations, but not in 2001. Finally, we found in 2002 that Health Canada is still developing the tools it needs to assist in evaluation, performance measurement, and risk assessment.

Conclusion

2.105 Since our audit in 1999, Health Canada has made progress in establishing a national framework that allows for greater collaboration among the partners involved in health surveillance. It has also made progress in defining roles and responsibilities for responding to public health threats. However, for the most part, it still has no agreement with the other partners on important matters such as data sharing, common standards, and nationally reportable diseases.

2.106 Many of Health Canada's existing disease surveillance systems still lack timely, accurate, and complete disease information, although some surveillance systems have improved. To address some of the weaknesses in the surveillance of communicable diseases, Health Canada and the provinces have undertaken to co-operate on developing the Canadian Integrated Public Health Information Surveillance Project. They have made progress, but full implementation is not likely for some time.

2.107 For the most part, diabetes and breast cancer are the only chronic diseases with a national surveillance system. The Department has allocated

only limited resources to the surveillance of other chronic diseases, despite the recognized importance of this activity, and it lacks health surveillance information on cardiovascular disease, cancer (except breast cancer), musculoskeletal disease, chronic respiratory disease, mental illness, and injuries. Further, it is lacking in surveillance of risk determinants and the impact of interventions, screening, and treatment on health outcomes.

2.108 We identified several issues that Health Canada needs to resolve. At present, these issues are impeding or preventing progress. Many of them are financial issues. The Department lacks the financial capacity to fill gaps in the surveillance of chronic disease. It also lacks the financial capacity to maintain chronic disease surveillance systems. Further, the internal exercise of resource reallocation results in an erosion of financial capacity. Finally, Health Canada needs to set priorities for health surveillance activities and provide adequate funding to support those priorities.

2.109 Health Canada's evaluation, performance measurement, and reporting of results of its health surveillance activities remain weak.

2.110 We recognize that Health Canada is not solely responsible for a number of these weaknesses. We encourage it to continue to show strong leadership for collaboration and co-operation among all the partners in health surveillance to address these problems.

About the Follow-Up

Objective

The objective of this audit was to determine the progress made by Health Canada in developing the following:

- common standards and protocols to facilitate collaboration and sharing of information among all the players in the health surveillance process;
- means to ensure that required surveillance systems provide timely and relevant information to anticipate, prevent, and respond to health threats and emerging health risks;
- adequate procedures to measure performance and report results;
- solutions to identified problems.

Scope

The follow-up audit focussed on the recommendations made in our 1999 Report—Chapter 14, National Health Surveillance: Diseases and Injuries; and Chapter 15, Management of a Food-borne Disease Outbreak. We also followed up on recommendations made by the Standing Committee on Public Accounts. Health Canada has undertaken a number of new initiatives in the last three years, which we also reviewed.

We reviewed a departmental status report on the action taken in response to the recommendations. We carried out extensive interviews with Health Canada staff involved in surveillance activities. We also met with provincial health officials in several provinces and with local medical officers of health in several regions. Finally, we reviewed documentation supporting Health Canada's activities in health surveillance.

Our report presents the results of the areas that were re-audited.

Criteria

We expected that Health Canada would have made satisfactory progress in implementing our recommendations and those of the Public Accounts Committee.

The criteria from the 1999 audits remain relevant. Therefore, we expected that

- all players in health surveillance would clearly understand Health Canada's role and responsibilities in the national health surveillance process;
- a full range of documented protocols and procedures would exist that indicate clearly what each player should do when a disease outbreak or health threat occurs;
- all players in the health surveillance process would use common standards and protocols for classifying, collecting, and reporting data on diseases and injuries to ensure that all information is comparable across the country;
- Health Canada's surveillance systems for monitoring diseases and injuries would enable it to collect, analyze, and disseminate all the information needed to help anticipate, prevent, and respond to existing and emerging health risk;
- there would be procedures to measure the effectiveness of health surveillance activities and report results;
- Health Canada's health surveillance activities would be based on a sound risk-benefit approach and a rational priority-setting framework; and
- Health Canada would take appropriate action to resolve identified problems.

Ratings

We assessed the action of departments/agencies against our original audit recommendations (see Key Message at the beginning of the Chapter). We used the following ratings:

- **Completed.** Corrective action has been fully implemented
- **Satisfactory progress.** Progress is being made at a satisfactory pace
- **Limited progress.** Some progress is being made, but the pace or scope is not satisfactory
- **No progress.** No evidence of progress although the department or agency accepted the recommendation from the original audit
- **Rejected.** The department or agency did not accept the recommendation from the original audit
- **Unknown.** Status of progress is unknown or information is not available

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Chapter

3

Health Canada

Federal Support of Health Care Delivery

The audit work reported in this chapter was conducted in accordance with the legislative mandate, policies, and practices of the Office of the Auditor General of Canada. These policies and practices embrace the standards recommended by the Canadian Institute of Chartered Accountants.

Table of Contents

Key Message 1

Introduction 3

The federal government is a significant player in health care 3

Canada has a long history of publicly financed health care 3

The federal government influences health care delivery through the *Canada Health Act* and the Canada Health and Social Transfer 6

There are variations in the delivery of publicly funded health care services 6

Recent increases in public health care expenditures 7

Weaknesses we identified in 1999 8

Focus of the follow-up 8

Observations and Recommendations 8

Federal contribution to health care is still unclear 8

Monitoring compliance with the *Canada Health Act* 11

Increased monitoring capacity 11

Limited number of information sources for monitoring 12

Limited access to the information that could identify non-compliance 12

Health Canada still does not report the extent of compliance 13

First Ministers agree to report publicly on performance of their health care systems 14

When non-compliance has been identified, resolution continues to be slow 15

When non-compliance issues cannot be resolved, penalties may be imposed 16

Few penalties have been imposed 16

Evaluating and reporting performance 16

Commitment to reporting on performance and effectiveness 18

Conclusion 19

About the Follow-Up 20

Health Canada
Federal Support of Health Care Delivery

Assistant Auditor General: Maria Barrados
Principal: Patricia MacDonald

Key Message

3.1 Health Canada has made only limited progress in addressing the weaknesses we identified in our 1999 audit. As a result, its monitoring still does not allow it to assess and report the extent of provincial and territorial compliance with the *Canada Health Act*. Resolving disputes over compliance with the Act remains slow. Both levels of government recently agreed to a process for dispute avoidance and resolution that holds potential for improving the resolution of disputes through co-operation and collaboration. The federal government still does not identify its intended contribution to health care funding. Parliament and Canadians need that information for informed debate on the future of health care.

ORIGINAL ISSUES	STATUS	RATING*
3.2 Health Canada should assess the capacity of the information sources it uses for monitoring the operation of the *Canada Health Act* and determining the extent to which provinces and territories have satisfied the Act's criteria and conditions.	Health Canada has increased its staff and budget to monitor and assess compliance with the Act. It has also developed a process for consistent, proactive monitoring and improved its information systems. Health Canada needs to continue to work with the provinces and territories because it still does not have adequate information to assess the extent of provincial and territorial compliance with the *Canada Health Act* criteria and conditions for health care funding.	LIMITED PROGRESS
3.3 In its annual reports to Parliament, Health Canada should clearly indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons.	The Canada Health Act Annual Report provides a good description of provincial and territorial health care insurance legislation, as well as statistics on health care delivery. The Report does not indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions.	LIMITED PROGRESS
3.4 The federal government should explore options to improve information on its total contribution to provinces and territories for health care.	The federal government provides only limited information on its intended total contribution to the provinces and territories for future funding of health care.	LIMITED PROGRESS

* Possible ratings are completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Follow-Up for an explanation of the ratings.)

Health Canada and the federal government have responded. Health Canada has not agreed with the recommendations but will address any gaps with regard to information collection in order to fulfill its obligations to administer the *Canada Health Act*. Health Canada has committed to further improving its performance measurement and reporting. The federal government has agreed to continue to explore options to improve health care information. The responses are included in the chapter.

Introduction

The federal government is a significant player in health care

3.5 The federal government is not directly responsible for the delivery of health care services in the provinces and territories; that is a provincial and territorial responsibility. However, the federal government supports health care by transferring funds to the provinces and territories to assist them in carrying out their health care mandates.

3.6 The federal government funds health care in a variety of ways. It provides direct funding for research, surveillance, and the development of the health "infostructure." It also funds grants and contributions to individuals and organizations to participate in activities such as health promotion, health protection, disease prevention, and health research. The federal government does deliver health care services directly to specific groups of people, such as First Nations and Inuit, the Canadian Forces, veterans, inmates of federal penitentiaries, and members of the Royal Canadian Mounted Police.

3.7 The largest federal transfer to the provinces and territories provides support for health care, post-secondary education, and social assistance. These transfers and the other forms of health care funding make the federal government a significant player in health care.

Canada has a long history of publicly financed health care

3.8 Until the late 1940s, health care in Canada was dominated by private medicine and access to care was based on ability to pay for it. In 1947, Saskatchewan introduced a public insurance plan for hospital services that covered all residents, regardless of their ability to pay. This began the evolution of Canadian health care into the system we have today, a system that is publicly funded and aims to ensure that all residents of Canada have prepaid access to the health care they need. Exhibit 3.1 summarizes the key milestones in this evolution.

3.9 In 1957, the federal government introduced the *Hospital Insurance and Diagnostic Services Act* in an attempt to encourage all provinces to develop hospital insurance plans. Under the Act, the federal government offered to share the costs of eligible services roughly fifty-fifty with the provinces. As a condition for receiving federal money, the provinces and territories agreed to make insured services available to all of their residents on uniform terms and conditions. By 1961, all 10 provinces and the two territories had signed agreements establishing public insurance plans that provided universal coverage for in-patient hospital care.

3.10 In 1966 the government introduced the *Medical Care Act*, which provided for federal funding to cover close to half the cost of physician visits and services. To qualify for federal funding, a province or territory had to ensure that its medical insurance plan satisfied four criteria: it had to be publicly administered, portable, and universal; and insured services had to be

accessible. By 1972, all provinces and territories had extended their health insurance plans to include physician services.

3.11 The Canada Assistance Plan was also introduced in 1966. This was a federal–provincial program for sharing the costs of comprehensive welfare services. In 1977, the federal government established the Extended Health Care Services Program to provide financial assistance to the provinces and territories for ambulatory care, nursing home intermediate care, adult residential care, and home health care.

3.12 In 1977, the federal government replaced cost sharing with block funding. This move responded to concerns about the expense and unpredictability of cost sharing and allowed more flexibility for the provinces to set their spending priorities. A new mechanism for block fund transfers was introduced, called Established Programs Financing (EPF). The EPF combined federal transfers for hospital and medical services with transfers for post-secondary education and the Extended Health Care Services Program.

3.13 The federal health transfer through Established Programs Financing was in roughly equal portions of cash and tax point transfers. To provide the tax transfer, the federal government reduced its personal and corporate income tax rates, which allowed provinces to raise their tax rates by an equal amount. As a result, the revenue that would have flowed to the federal

Exhibit 3.1 Key milestones in the evolution of universal, publicly financed health care in Canada

[illegible]	Saskatchewan introduced a public insurance plan for hospital services.
[illegible]	The federal government introduced the *Hospital Insurance and Diagnostic Services Act*, a cost-shared program providing insurance coverage and access to hospital services.
[illegible]	Provinces and territories joined the national hospital insurance program.
[illegible]	Saskatchewan extended public health insurance to cover physician services outside hospitals.
[illegible]	The federal government introduced the *Medical Care Act* to share the cost of medical care insurance plans with provinces.
[illegible]	The federal government introduced the Canada Assistance Plan (CAP), a cost sharing plan for comprehensive welfare programs. The plan also covered certain health services.
[illegible]	Provinces and territories joined the national medical care program.
[illegible]	The *Federal–Provincial Fiscal Arrangements and Established Programs Financing Act* was enacted. Established Programs Financing (EPF) included transfers covering hospital insurance, medical care insurance, and post-secondary education; and the Extended Health Care Services Program.
[illegible]	Parliament enacted the *Canada Health Act*.
[illegible]	The federal government replaced EPF and CAP with the Canada Health and Social Transfer (CHST).
[illegible]	The Prime minister and all premiers (except Quebec's) and territorial leaders signed the Social Union Framework Agreement.
[illegible]	First ministers issued a communiqué on health that committed them to clear accountability reporting to Canadians.

government began to flow directly to the provincial governments. This revenue still goes to the provinces and continues to grow as their economies grow.

3.14 The *Canada Health Act* was passed in 1984, when Established Programs Financing was the main mechanism for transferring federal funds to the provinces for health care. The Act was a response to concerns that doctors' practice of extra-billing and hospitals' charging of user fees were creating a two-tiered health system that would threaten access to care. The *Canada Health Act* reaffirmed the federal government's commitment to universal, accessible, comprehensive, portable, and publicly administered health insurance (Exhibit 3.2).

Exhibit 3.2 *Canada Health Act*: Purpose and requirements

Purpose

The *Canada Health Act* aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis.

The purpose of the *Canada Health Act* is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

Criteria

1. **Public administration.** The health insurance plan of a province/territory must be administered and operated on a non-profit basis by a public authority accountable to the provincial/territorial government.
2. **Comprehensiveness.** The plan must insure all medically necessary services provided by hospitals and physicians and, where permitted, services rendered by other health care practitioners.
3. **Universality.** The plan must entitle 100 percent of eligible residents to insured health services on uniform terms and conditions.
4. **Portability.** Residents are entitled to coverage when they move to another province/territory and when they travel within Canada or abroad (with some restrictions).
5. **Accessibility.** The plan must provide reasonable access to insured hospital and physician services on uniform terms and conditions. Additional charges to insured patients for insured services are not allowed. No one may be discriminated against on the basis of income, age, health status, etc.

Conditions

1. **Provision of information.** Provincial/territorial governments are required by regulations to provide annual estimates and statements on extra-billing and user charges. They are also required to voluntarily provide an annual statement describing the operation of their plans as they relate to the criteria and conditions of the Act. This information serves as a basis for the Canada Health Act Annual Report.
2. **Provincial recognition of federal contributions.** Provincial/territorial governments are required to give public recognition of federal transfers.

Provisions on extra-billing and user charges

1. **Extra-billing** for an amount in addition to any amount paid or to be paid for an insured health service by the health care insurance plan of a province.
2. **User charge** for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by the plan, but does not include any charge imposed by extra-billing.

Penalty provisions

1. **Mandatory financial penalty** for extra-billing and user charges. Direct patient charges are subject to dollar-for-dollar deductions from federal transfer payments.
2. **Discretionary financial penalty** for non-compliance with the five criteria and two conditions. Financial penalties will reflect the gravity of the default.

Source: Health Canada, *Canada Health Act Annual Report*, 1997–98

accessible. By 1972, all provinces and territories had extended their health insurance plans to include physician services.

3.11 The Canada Assistance Plan was also introduced in 1966. This was a federal–provincial program for sharing the costs of comprehensive welfare services. In 1977, the federal government established the Extended Health Care Services Program to provide financial assistance to the provinces and territories for ambulatory care, nursing home intermediate care, adult residential care, and home health care.

3.12 In 1977, the federal government replaced cost sharing with block funding. This move responded to concerns about the expense and unpredictability of cost sharing and allowed more flexibility for the provinces to set their spending priorities. A new mechanism for block fund transfers was introduced, called Established Programs Financing (EPF). The EPF combined federal transfers for hospital and medical services with transfers for post-secondary education and the Extended Health Care Services Program.

3.13 The federal health transfer through Established Programs Financing was in roughly equal portions of cash and tax point transfers. To provide the tax transfer, the federal government reduced its personal and corporate income tax rates, which allowed provinces to raise their tax rates by an equal amount. As a result, the revenue that would have flowed to the federal

Exhibit 3.1 Key milestones in the evolution of universal, publicly financed health care in Canada

	Saskatchewan introduced a public insurance plan for hospital services.
	The federal government introduced the *Hospital Insurance and Diagnostic Services Act*, a cost-shared program providing insurance coverage and access to hospital services.
	Provinces and territories joined the national hospital insurance program.
	Saskatchewan extended public health insurance to cover physician services outside hospitals.
	The federal government introduced the *Medical Care Act* to share the cost of medical care insurance plans with provinces.
	The federal government introduced the Canada Assistance Plan (CAP), a cost sharing plan for comprehensive welfare programs. The plan also covered certain health services.
	Provinces and territories joined the national medical care program.
	The *Federal–Provincial Fiscal Arrangements and Established Programs Financing Act* was enacted. Established Programs Financing (EPF) included transfers covering hospital insurance, medical care insurance, and post-secondary education; and the Extended Health Care Services Program.
	Parliament enacted the *Canada Health Act*.
	The federal government replaced EPF and CAP with the Canada Health and Social Transfer (CHST).
	The Prime minister and all premiers (except Quebec's) and territorial leaders signed the Social Union Framework Agreement.
	First ministers issued a communiqué on health that committed them to clear accountability reporting to Canadians.

government began to flow directly to the provincial governments. This revenue still goes to the provinces and continues to grow as their economies grow.

3.14 The *Canada Health Act* was passed in 1984, when Established Programs Financing was the main mechanism for transferring federal funds to the provinces for health care. The Act was a response to concerns that doctors' practice of extra-billing and hospitals' charging of user fees were creating a two-tiered health system that would threaten access to care. The *Canada Health Act* reaffirmed the federal government's commitment to universal, accessible, comprehensive, portable, and publicly administered health insurance (Exhibit 3.2).

Exhibit 3.2 *Canada Health Act*: Purpose and requirements

Purpose

The *Canada Health Act* aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis.

The purpose of the *Canada Health Act* is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

Criteria

1. **Public administration.** The health insurance plan of a province/territory must be administered and operated on a non-profit basis by a public authority accountable to the provincial/territorial government.
2. **Comprehensiveness.** The plan must insure all medically necessary services provided by hospitals and physicians and, where permitted, services rendered by other health care practitioners.
3. **Universality.** The plan must entitle 100 percent of eligible residents to insured health services on uniform terms and conditions.
4. **Portability.** Residents are entitled to coverage when they move to another province/territory and when they travel within Canada or abroad (with some restrictions).
5. **Accessibility.** The plan must provide reasonable access to insured hospital and physician services on uniform terms and conditions. Additional charges to insured patients for insured services are not allowed. No one may be discriminated against on the basis of income, age, health status, etc.

Conditions

1. **Provision of information.** Provincial/territorial governments are required by regulations to provide annual estimates and statements on extra-billing and user charges. They are also required to voluntarily provide an annual statement describing the operation of their plans as they relate to the criteria and conditions of the Act. This information serves as a basis for the Canada Health Act Annual Report.
2. **Provincial recognition of federal contributions.** Provincial/territorial governments are required to give public recognition of federal transfers.

Provisions on extra-billing and user charges

1. **Extra-billing** for an amount in addition to any amount paid or to be paid for an insured health service by the health care insurance plan of a province.
2. **User charge** for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by the plan, but does not include any charge imposed by extra-billing.

Penalty provisions

1. **Mandatory financial penalty** for extra-billing and user charges. Direct patient charges are subject to dollar-for-dollar deductions from federal transfer payments.
2. **Discretionary financial penalty** for non-compliance with the five criteria and two conditions. Financial penalties will reflect the gravity of the default.

Source: Health Canada, *Canada Health Act Annual Report*, 1997–98

3.15 In 1996, the Canada Health and Social Transfer (CHST) was introduced to replace Established Programs Financing and the Canada Assistance Plan. The CHST is a block fund or lump sum transfer from the federal government to the provinces and territories on a per capita basis to subsidize health care, post-secondary education, and social assistance. The provinces allocate the block fund among these social programs according to their own priorities.

The federal government influences health care delivery through the *Canada Health Act* and the Canada Health and Social Transfer

3.16 The federal government does not legislate health care directly. Instead, through the *Canada Health Act*, it supports the conditional transfer of payments to the provinces and territories for health care. The Canada Health and Social Transfer, administered by the Department of Finance through the *Federal-Provincial Fiscal Arrangements Act*, is a means by which the federal government influences health care in Canada.

3.17 By imposing conditions on the transfer of funds through the CHST, the *Canada Health Act* seeks to ensure that medically necessary services will be universally accessible, without direct charge, to residents of all Canadian provinces and territories. The conditions the Act imposes are its five criteria (Exhibit 3.2). The Act states that, in order that a province may qualify for a full cash contribution... [under the CHST], the health care insurance plan of the province must satisfy the criteria respecting: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility.

3.18 The five criteria of the *Canada Health Act* reflect national objectives. Health Canada's role is to assess the extent to which health care delivery in the provinces and territories complies with the Act's criteria and provisions and to authorize the payment of the CHST based on that assessment.

There are variations in the delivery of publicly funded health care services

3.19 The *Canada Health Act* covers hospital, physician, and surgical-dental services in a hospital that are judged to be medically necessary and requires, under the criterion of comprehensiveness, that these services be insured by provincial health care insurance plans. Achieving comprehensiveness does not ensure the public funding of the same set of health care services in every province. There are a number of reasons for a lack of uniformity. First, the term "medically necessary" is not defined in the legislation, and may be interpreted differently in each province. Further, the provinces and territories do not use a uniform method for determining which services are medically necessary. Similarly, each province and territory is separately and independently responsible for its own decisions to delist any medical services, that is, to no longer pay for them through the public health care insurance plan. Finally, each provincial health care insurance plan covers additional services that are not covered by the CHA but are publicly funded through the provincial plan. These additional services vary from province to province.

3.20 For all of these reasons, there are variations across the country in public coverage of certain health care services. For instance, the removal of

varicose veins and eye examinations for people aged 19 to 64 are medical services that are insured in some provinces but not in others. The extent and the impact of variations across the country are not known.

Recent increases in public health care expenditures

3.21 During the period 1991 to 1997, the proportion of public to total expenditure on health care declined. After 1997 the trend reversed, because the federal government announced significant increases in the CHST (Exhibit 3.3).

3.22 The pattern of health care spending has changed over the past decade. Spending on hospital and physician services has become a smaller percentage of total health care spending. These services are covered by the *Canada Health Act*. Health care expenditures for drugs have increased as a percentage of total health care expenditures. Drugs are not covered by the *Canada Health Act* unless they are administered in a hospital.

3.23 In 1984, when the *Canada Health Act* was passed, hospitals provided many services such as drugs, rehabilitation, convalescent care, and palliative care that today are delivered increasingly in the home or community. And they are delivered by a broader range of health care providers, such as nurses, nurse practitioners, physiotherapists, and occupational therapists. These services fall outside the scope of the *Canada Health Act*, and their delivery is often paid for by patients or by private health insurance plans.

Exhibit 3.3 Health care spending in Canada, 1991 to 2001

	1991	1993	1995	1997	1999	2001 (Forecast)
Total health care expenditure ($ billions)	66.2	71.5	74.1	78.3	89.5	102.5
Public health care expenditure ($ billions)	49.35	51.95	52.8	55	63.4	74.5
Private health care expenditure ($ billions)	16.89	19.56	21.3	23.3	26.1	28
Total health care expenditure as a percentage of GDP	9.6	9.8	9.1	8.9	9.2	9.4
Public health care expenditure as a percentage of total	74.5	72.7	71.3	70.2	70.8	72.7
Private health care expenditure as a percentage of total	25.5	27.3	28.7	29.8	29.2	27.3
Total health care expenditures by use of funds as a percentage of total						
Hospitals	38.7	37.4	34.5	33.0	31.9	31.5
Physicians	15.4	14.7	14.3	14.2	13.6	13.5
Drugs (prescribed and non-prescribed)	11.6	12.7	13.5	14.4	14.9	15.2
Other	34.3	35.2	37.7	38.4	39.6	39.8

Source: Canadian Institute for Health Information

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Source: Canadian Institute for Health Information

Weaknesses we identified in 1999

3.24 Our 1999 audit examined the *Canada Health Act* and the Canada Health and Social Transfer, the federal government's key mechanisms of support to the provinces and territories in their delivery of health care. Our 1999 Report (Chapter 29) discussed the way the government had used these tools as instruments of public policy, the purposes they had served, and their effectiveness in achieving the results they were designed to achieve.

3.25 We noted several weaknesses in Health Canada's reporting, monitoring, and enforcement activities, such as the following:

- The federal contribution to health care was not being reported to either Parliament or the Canadian public.
- Health Canada did not have the information it needed for effective monitoring of provincial and territorial compliance with the *Canada Health Act*.
- The Department was not reporting the extent to which the provinces and territories were complying with the Act.
- It was not rigorously enforcing the Act.

Focus of the follow-up

3.26 Our follow-up audit reviewed the current administration of the *Canada Health Act* in light of our 1999 observations and recommendations.

3.27 We looked specifically at Health Canada's activities and systems for collecting information. We assessed the Department's capacity to collect and use information to monitor and report on compliance with the Act. We examined the enforcement of the Act. Finally, we examined the Department's development of a mechanism for resolving disputes with a province or territory. Our report presents the results of the areas that were re-audited. Further details can be found about the follow-up's objectives, scope, approach, and criteria in About the Follow-Up at the end of the chapter.

Observations and Recommendations

Federal contribution to health care is still unclear

3.28 In our 1999 report, we observed that the federal government could not say how much it contributed, in total, to health care. We recognized that the design of the CHST as a block transfer meant that Parliament and the general public also had no clear idea of the amount of federal funding that was directed to health care. We also made clear our expectation that the federal government be in a position to provide Canadians with information on its contribution to health care.

3.29 The design of the CHST as a block transfer reflects a federal policy decision to give the provinces and territories more flexibility to allocate resources among the designated areas of social funding. Although the total amount allocated to social programs is known, Canadians do not know what portion of the CHST the federal government intends to contribute to health care.

3.30 In 2000, the Department of Finance made a number of estimates of the federal government's support to health provided through transfers to the provinces and territories. One of the estimates assumed the same historical allocation to health that prevailed under the transfer system prior to 1996–97 (43 percent cash and 68 percent tax points, for a weighted average of 54.3 percent). The other estimates suggested that the allocation might be higher. The Department of Finance told us that the estimate based on historical allocation was made for illustrative purposes only. In recent years, the federal government has invested additional funds, primarily for health, through the CHST (Exhibit 3.4). In July 2002, the Department of Finance made a new estimate based on provincial spending on health and other social programs covered by the CHST. Using the same breakdown, it estimated that 62 percent of the CHST ($21 billion in 2001–02), on average, is spent on health annually.

3.31 No distinction is made in the CHST to indicate how much is intended for each of the social programs it funds. The federal transfer is a combination of cash contributions and tax points for the delivery of health care, post-secondary education, and social assistance (Exhibit 3.5). There is no agreed-upon estimate that captures the federal contribution to health care. The Canadian public has not had a clear idea of the amount of federal funding directed to health care. Nor can the federal government say what its total contribution to health care will be. Consequently, parliamentarians must make decisions about federal support of health care delivery without adequate information on the federal contribution.

Exhibit 3.4 Recent federal investments in health care

	The federal Budget announced increased funding for the Canada Health and Social Transfer (CHST) of $11.5 billion over five years, specifically for health care.
	The Budget announced a $2.5 billion increase in the CHST over four years to help provinces and territories fund post-secondary education and health care. First Ministers agreed on an action plan for renewing health care and investing in early childhood development. The federal government committed to invest an additional $21.1 billion in the CHST over five years, including $2.2 billion for early childhood development. It would also invest in three targeted areas: • $1 billion in 2000–01 and 2001–02, in transfers to the provinces and territories for new medical equipment; • $800 million over four years, beginning in 2001–02, in a renewed Health Transition Fund to support innovation and reform in primary care; and • $500 million to establish an independent corporation mandated to accelerate the development and adoption of modern systems of information technology, such as electronic patients' records.

Source: Department of Finance

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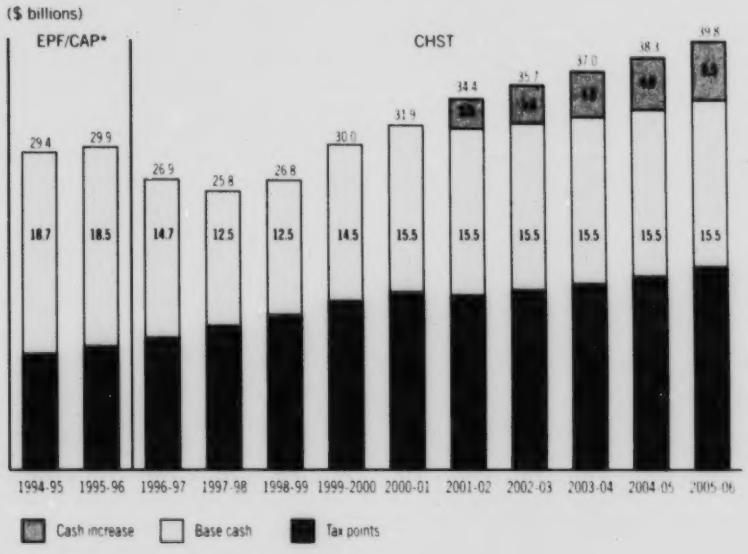
Source: Department of Finance

Exhibit 3.5 Canada Health and Social Transfer (CHST)



*EPF Established Programs Financing
CAP Canada Assistance Plan

Source: Department of Finance, at 22 July 2002

3.32 Public opinion polls show that Canadians value Medicare and are concerned about its long-term sustainability. There is considerable debate over the federal contribution to health care. Much of the debate has been about incremental funding—that is, reductions in or additions to the federal contribution.

3.33 In 2000, the federal government put an additional $21.1 billion into the CHST for five years. This increase was targeted primarily to support health care delivery in the provinces and territories. When the increase was announced, First Ministers agreed to improve public reporting in their own provinces as a way to inform Canadians about some of the effects of health care spending.

3.34 The current public debate on the future of health care is evidence of Canadians' concern about their health care system. The debate is limited by a lack of sufficient information on the federal contribution to health care funding: Canadians do not know how much the federal government contributes. We would expect the federal government to be in a position to tell Canadians what it intends to contribute to health care funding in the future. This information could help to inform the current debate on health care reform. Further, federal efforts to spell out its own intent would not affect the flexibility of the provinces and territories to allocate the CHST block funding according to their own priorities.

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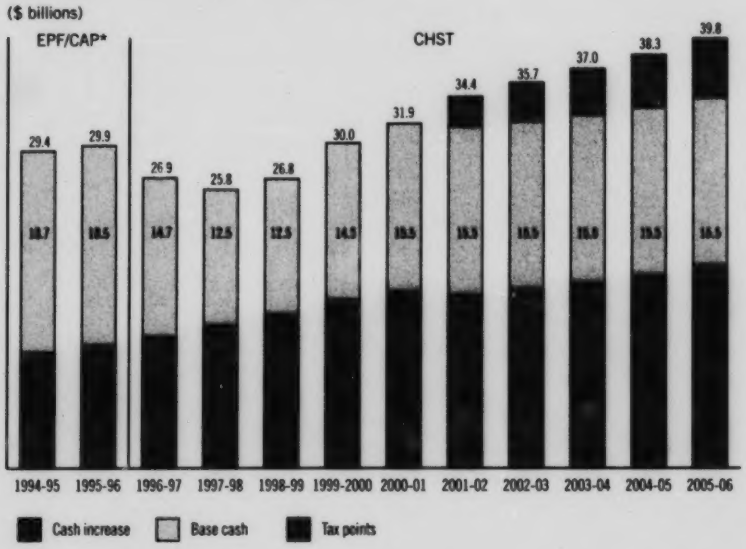

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3.35 **Recommendation.** The federal government should provide sufficient information to Parliament to allow for informed debate on future health care funding.

Government's response. The federal government provides full information on its own direct health spending through the Main Estimates and the Health Canada Web site. It also provides full information (in Budget booklets, the Finance Canada Web site, and the Main Estimates) on its transfer payments to provinces and territories, which, in the case of the Canada Health and Social Transfer (CHST), is provided to support provincial and territorial spending on health care, post-secondary education, and social assistance and social services, including early childhood development. The policy intent in establishing the CHST block fund is to provide provinces and territories with the flexibility to allocate funds according to their respective priorities; in this context, provinces and territories have the flexibility to use all of the CHST cash in support of the *Canada Health Act* if they wish. The federal government has made strides in ensuring that more information is made available on the nature and policy objectives of transfer programs, including the CHST, and will continue to explore options to improve health care information.

Monitoring compliance with the *Canada Health Act*

3.36 We observed in 1999 that Health Canada did not routinely collect the information it needed for determining to what extent the provinces and territories were complying with the *Canada Health Act*. We noted that its sources of information were not sufficient to determine the extent of compliance. We also noted that the Department had not collected reliable information on relevant indicators.

3.37 We expected Health Canada to use a monitoring system that collected sufficient relevant information on compliance with the *Canada Health Act*, analyzed it, reported it, and provided the Department with the information it needed to administer the Act.

Increased monitoring capacity

3.38 A reorganization at Health Canada in 2000 created the Canada Health Act Division. The new division's major responsibilities include monitoring provincial and territorial health insurance plans to ensure that they meet the criteria and conditions of the Act; informing the Minister of possible non-compliance and recommending appropriate action to resolve it; providing information to senior Health Canada officials on the monitoring and interpretation of the Act; reporting annually to Parliament on provincial and territorial compliance with the Act; and administering and enforcing the Act.

3.39 In the Canada Health Act Division, annual funding was increased from $2.5 million in 1999 to $4 million; the additional funding was to support activities in the Department's regions and at headquarters. Two new positions were created in each of Health Canada's six regions, and the total staff complement of the Division rose from 23 to 49. We were told that the new positions are responsible primarily to collect information for the purposes of monitoring compliance with the Act.

3.40 At headquarters, Health Canada established the Information, Analysis and Reporting Unit, responsible for collecting and analyzing information to improve the Department's capacity to monitor provincial and territorial compliance with the *Canada Health Act*. The Unit developed the Canada Health Act Information System to facilitate the storage, tracking, and analysis of information related to compliance. The unit is also responsible for producing the Canada Health Act Annual Report.

Limited number of information sources for monitoring

3.41 Our follow-up found that the sources of information Health Canada uses for monitoring purposes have not changed substantially since our 1999 audit. There are three major sources of information available to the regional analysts—third-party sources, public complaints, and voluntary submissions by the provinces and territories for the purpose of the annual report.

3.42 Third-party sources include the media, stakeholders' publications, personal and professional contacts, and conferences. The Department's regional analysts rely heavily on these sources to track and identify potential cases of non-compliance in the provincial delivery of health care. These sources still do not allow the Department to assess the extent of provinces' and territories' compliance with the *Canada Health Act*.

3.43 Complaints by individuals are the second major source of information on potential cases of non-compliance. Complaints trigger queries and investigations that can lead to the identification of cases of non-compliance with the conditions of the *Canada Health Act*. Complaint-driven monitoring assumes that where no complaints are reported, conditions are being met.

3.44 Finally, the provinces and territories submit information voluntarily to Health Canada each year, according to guidelines developed by the Department. This information describes the operation of the provincial and territorial health care insurance plans in relation to the Act. The information is analyzed by the Department to ensure that provincial and territorial health care insurance legislation comply with the *Canada Health Act*.

3.45 As in 1999, we found that these sources alone do not provide sufficient information to monitor compliance and determine the extent of compliance. Information the Department provided to us shows that none of the investigations of potential non-compliance initiated since 1999 has been related to the criteria of the Act. All new investigations reported to us have dealt with the provisions of the Act, that is, user charges and extra-billing. The fact that there are no investigations related to the criteria of the Act raises some questions.

3.46 We are concerned that there may be cases of non-compliance with the criteria of the Act that Health Canada has not investigated.

Limited access to the information that could identify non-compliance

3.47 There are no regulations that require the provinces and territories to submit specific information to Health Canada, apart from extra-billing and user charges. Health Canada attempts to monitor health care delivery in the

provinces and territories in the absence of required reporting. While the Act places conditions on the transfer of CHST funds to the provinces for health care delivery, the legislation does not include regulations to facilitate monitoring for provincial compliance with these conditions. When the Act was passed in 1984, regulations were drafted to require reporting; however, they were never promulgated. As a result, the Department has only limited ability to obtain the information it needs from the provinces.

3.48 The *Canada Health Act* defines the conditions for the federal transfer of funds to the provinces for health care. It also includes a provision for obtaining the information Health Canada needs from the provinces and territories. That provision has not been exercised. In its interactions with the provinces and territories, Health Canada has tended to take a non-intrusive approach to administering the *Canada Health Act*.

3.49 The Department's regional analysts informed us that they cannot collect information from medical facilities because delivery of services is under provincial and territorial jurisdiction. The provinces and territories are responsible for ensuring that health care delivery complies with their own health care legislation; they are not obliged to report this information to Health Canada. Thus, Health Canada does not have access to the information it needs to administer the Act.

3.50 We observed that other organizations collect data on health care delivery. The Canadian Institute for Health Information (CIHI) has collected information on waiting times in hospitals; Statistics Canada conducts the Canadian Community Health survey; and organizations outside government, such as the Canadian Medical Association and the Canadian Healthcare Association, also collect health statistics. While these organizations do not have the same mandate as Health Canada, they do collect some information that Health Canada could use for monitoring but currently is not.

Health Canada still does not report the extent of compliance

3.51 We noted in 1999 that previous editions of the Canada Health Act Annual Report to Parliament had not met the Act's requirement that Health Canada indicate to what extent each province and territory had satisfied the criteria and conditions in the Act. The annual reports were descriptive and narrative, and they did not provide enough information for Parliament to determine the extent of provincial and territorial compliance.

3.52 The Minister of Health has an obligation under the Act to report on its administration and operation, including all relevant information on the extent to which the provinces have satisfied the conditions for payment under the Act.

3.53 The Canada Health Act Annual Report contains general descriptions of the non-compliance issues under investigation. It also shows, by province and territory, penalties levied during the previous year and annual deductions since the passage of the *Canada Health Act*.

3.54 Neither of the two most recent annual reports (1999–2000, 2000–01) contains an assessment of the extent to which the provincial health care insurance plans comply with the *Canada Health Act*. The provinces and territories voluntarily submit information to Health Canada as prescribed by a template developed by the Canada Health Act Division. This information is reported in the Canada Health Act Annual Report but is not used to determine compliance. The reports provide good descriptions of provincial and territorial health care insurance legislation. Health Canada does not conclude to what extent this legislation complies with the *Canada Health Act*. The reports also provide statistics on health care delivery. Health Canada does not conclude to what extent provincial and territorial health care delivery complies with the federal legislation. As a result, members of Parliament cannot determine from the Canada Health Act Annual Report whether the spending of billions of dollars transferred to the provinces and territories results in health care delivery that meets the intent of the Act.

First Ministers agree to report publicly on performance of their health care systems

3.55 In September 2000, First Ministers issued a communiqué on health that committed them to clear accountability reporting to Canadians. This accompanied the announcement of $21.1 billion in new federal investments over five years to support health care renewal.

3.56 First Ministers directed their health ministers to collaborate on developing 14 indicator areas against which each government would begin reporting by September 2002. These indicator areas are to address health status, health outcomes, and quality of service. Public reporting would include verification by an independent party.

3.57 Each jurisdiction (federal, provincial, and territorial) was to report to its constituents in September 2002 on the 14 indicator areas agreed on. This initiative represents a step in the right direction. Among the indicators, two relate to compliance (hospital waiting times and access to first-contact health services). If the governments pursue this initiative and continue to collaborate on developing additional indicators, this type of reporting could provide Canadians with information on the public administration, universality, accessibility, comprehensiveness, and portability of health care.

3.58 Health Canada recognizes that there are shortcomings in the collection of health information. First Ministers are committed to working together on the development of a comprehensive framework using jointly agreed comparable indicators to address health status, health outcomes, and quality of service. To improve monitoring and reporting requires the collaboration of provinces and territories with the federal government.

3.59 **Recommendation.** Health Canada should, in collaboration with the provinces and territories, fulfil its obligation to administer the *Canada Health Act* by collecting the information it needs to enforce and report compliance with the Act.

Health Canada's response. Health Canada is already collecting considerable information on the activities of provincial and territorial health insurance plans. This information is used to assess provincial and territorial compliance with the criteria and conditions of the *Canada Health Act* and to report to Parliament.

Any gaps with regard to information collection will be addressed in the context of the provisions of the *Canada Health Act* Dispute Avoidance and Resolution process agreed to by the provinces and territories in April 2002. The process allows for governments to engage in discussions, information exchange, and joint fact-finding to ensure that they have all the necessary information to assess concerns with regard to the interpretation of and compliance with the *Canada Health Act*.

When non-compliance has been identified, resolution continues to be slow

3.60 In 1999 we reported that the resolution of non-compliance issues was a slow process. We cited examples of suspected non-compliance that had remained unresolved for a number of years. At the time of that report, there were 14 unresolved issues. Three of them have since been resolved; the 11 remaining issues have been outstanding for five years or longer.

3.61 The process for resolving federal/provincial differences over compliance with the CHA has remained slow. Since 1999, Health Canada has identified 12 more cases of suspected or confirmed non-compliance and has attempted to deal with them through means other than penalties. Two of the issues have been resolved; 10 remain outstanding.

3.62 We have been told that the slow resolution of disputes is partly due to difficulties encountered in the interpretation of the *Canada Health Act*. We note that Health Canada has developed the *Canada Health Act* Policy Interpretation Manual for employees of the Canada Health Act Division. However, the Department has not shared the manual with the provinces and territories because of legal constraints. Consequently, different interpretations of the Act at various levels of government have hindered the timely resolution of problems. Enforcement of the *Canada Health Act*, whether through penalties or negotiations, could be facilitated by an attempt to ensure timely and ongoing discussion of the Act's interpretation by all parties.

3.63 In 1999 we recognized the need for federal/provincial/territorial collaboration to avoid disputes or resolve them, as a means of enforcing the Act. Co-operation and collaboration were the major themes of the Social Union Framework Agreement signed in February 1999 by the Prime Minister and all premiers (except Quebec's). The Agreement describes how federal, provincial, and territorial governments will work together to sustain Canada's social programs.

3.64 In the spirit of the Agreement, Health Canada is committed to administering the *Canada Health Act* in a non-intrusive manner and in collaboration with provincial and territorial governments. To this end, the Department has worked with the provinces and territories to develop a process to facilitate the avoidance of disputes and the resolution of non-

compliance issues. Agreement on the process was reached in April 2002. It has not been used yet, but it has potential for improving collaboration to avoid and resolve non-compliance issues.

When non-compliance issues cannot be resolved, penalties may be imposed

3.65 Negotiation is the first course of action in the dispute resolution process. If negotiation fails, the Minister may impose a penalty. The *Canada Health Act* provides for two kinds of penalty. The first is a mandatory penalty related only to the provisions of the Act that cover extra-billing and user charges. A mandatory penalty amounts to a dollar-for-dollar deduction from the federal CHST payment to the province or territory that has allowed extra-billing or user charges. The second type of penalty is a discretionary penalty. Under sections 14 to 17 of the Act, discretionary penalties (CHST reductions) can be imposed if a province or territory has not satisfied any one of the Act's criteria for health care delivery and if all reasonable efforts at consultation and negotiation have failed. At this point, the Minister may refer the matter to the Governor in Council for a decision on whether the CHST should be reduced.

3.66 In 1999 we observed that enforcement of the *Canada Health Act* through penalties for non-compliance had been limited to the mandatory penalty for non-compliance with the extra-billing and user fee provisions of the Act. The federal government had never applied the discretionary penalties for non-compliance with the criteria of the Act.

3.67 The Act imposes obligations on the federal government. It defines the conditions that the provinces must meet to receive federal payments. If a provincial health care insurance plan falls short of these conditions, the federal government has the legislative authority to take measures that can include withholding all contributions to the offending province.

Few penalties have been imposed

3.68 The Canada Health Act Annual Report 2001–2002 shows that the federal government imposed one penalty for user charges. Exhibit 3.6 shows the number of penalties imposed since 1995 and their total value.

3.69 Health Canada has told us that it hesitates to impose penalties. It has shown a strong preference for consultation and negotiation to resolve disputes in collaboration with the provinces and territories. It believes that if it were to impose penalties, the provinces and territories could simply choose to absorb them and continue to contravene the Act.

Evaluating and reporting performance

3.70 In 1999 we reported that an evaluation by the Department had focussed on the Health Insurance Division's procedures for monitoring whether provincial health care delivery met the accessibility criterion of the Act. The evaluation noted that it was not clear how effectively the Division monitored the status of the health care system, including the implications of emerging issues that affect the underlying principles of the Act.

Exhibit 3.6 Annual deductions from Canada Health and Social Transfer, by province and territory ($ thousands)

Province/ territory	1995–96		1996–97		1997–98		1998–99		1999–2000		2000–01		Total gross deductions 1995–96 to 2000–01		
	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Total
Newfoundland and Labrador		46		96		128		53						323	323
Prince Edward Island															
Nova Scotia		32		72		57		39		61		58		319	319
New Brunswick															
Quebec															
Ontario															
Manitoba		269		588		587		612						2,056	2,056
Saskatchewan															
Alberta		2,319		1,266										3,585	3,585
British Columbia	43												43		43
Yukon															
Northwest Territories															
Nunavut															
Provincial/ Territorial Total	43	2,666		2,022		772		704		61		58	43	6,283	6,326

Source: Health Canada, Canada Health Act Annual Report, 2000-2001

Exhibit 3.6 Annual deductions from Canada Health and Social Transfer, by province and territory ($ thousands)

[illegible]	[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Newfoundland and Labrador		46		96		128		53						323	323
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Provincial/ Territorial Total	43	2,666		2,022		772		704		61		58	43	6,283	6,326

Source: Health Canada, Canada Health Act Annual Report, 2000–2001

The evaluation examined only the Division's monitoring activities; it did not question, for example, whether Canadians do in fact have reasonable access to health services across the country.

3.71 Health Canada agreed with our recommendation to deal with key issues of the *Canada Health Act* in future evaluations. However, it has suspended further evaluation of its responsibilities under the *Canada Health Act*, in light of several ongoing studies of the health care system, including the following:

- Commission on the Future of Health Care in Canada (chaired by Roy Romanow), report expected in 2002
- Standing Senate Committee on Social Affairs, Science and Technology: *The Health of Canadians—The Federal Role* (tabled by Senator Kirby), two reports in 2001 and another three to be tabled in 2002
- Alberta Premier's Advisory Council on Health (chaired by Don Mazankowski), report tabled January 2002
- Saskatchewan Commission on Medicare (chaired by Ken Fyke), report tabled April 2001
- Quebec's Commission d'étude sur les services de santé et les services sociaux (chaired by Michel Clair), report tabled December 2000

Commitment to reporting on performance and effectiveness

3.72 The 1999 Budget announced the $43 million health-related Federal Accountability Initiative. The initiative committed Health Canada to becoming more accountable to Canadians for the performance of its own health programs. The Department lacked the capacity in 1999 to undertake the initiative and we recommended that it explore options to meet its commitment.

3.73 Our follow-up found that Health Canada has done some work on this initiative, for example, its Performance Measurement Development Project. However, it has not completed the project; it has not yet fully developed performance expectations and reported against them. The Department was not able to provide us with an action plan and target dates.

3.74 **Recommendation.** Health Canada should ensure that the Federal Accountability Initiative provides the required performance measures of its own programs and reports against them.

Health Canada's response. Health Canada's investment in the Federal Accountability Initiative has served to advance the Department's policies and practices with respect to performance measurement and reporting to Canadians.

Health Canada is meeting its commitments to develop indicators and report on them. As part of the September 2000 First Ministers' commitment to regular federal/provincial/territorial reporting on health system performance, Health Canada is preparing a report on performance, including data on First Nations health as well as information with regard to veterans, inmates, and military personnel. This report will be published in September 2002.

Health Canada is working expeditiously on the development of performance indicators for the Department, which will be the basis for further improvements in performance reporting. The indicators will be proposed for internal approval in September 2002 to be used in the departmental performance report in the following year.

Conclusion

3.75 Weaknesses in the information that Health Canada collects and reports annually to Parliament on the administration and operation of the *Canada Health Act* remain a long-standing problem. Increased monitoring has not been able to remedy the problem of limited sources of information. Health Canada does not use the information it collects to assess or report on the extent of provincial and territorial compliance with the criteria and conditions of the *Canada Health Act*.

3.76 Health Canada has tended to take a non-intrusive approach to administering the Act. However, this approach has not brought about the speedy resolution of issues related to non-compliance with and interpretation of the Act. The majority of the non-compliance issues identified by Health Canada over the past 10 years have remained unresolved for five years or longer. Few penalties have been levied for non-compliance with the provisions of the Act. No penalties have been levied for non-compliance with the criteria of the Act.

3.77 Health Canada has suspended its evaluation of programs in this area because of the number of ongoing studies of the health care delivery system. The Department remains committed to measuring and reporting on performance. However, it has not yet completed the Performance Management Development Project.

3.78 The federal government needs to provide Parliament with adequate information on its contribution to provinces and territories for health care. Meaningful participation in the current debate on health care depends on a better appreciation of the federal contribution to this social program, one that Canadians have said helps to define this country.

About the Follow-Up

Objective

The objective of this follow-up audit was to identify Health Canada's progress in determining the extent to which federal efforts to support and monitor health care delivery

- reflect clear objectives,
- adequately report performance, and
- facilitate review and evaluation.

Scope and approach

The follow-up audit focussed on the recommendations made in our 1999 Report, Chapter 29, Federal Support of Health Care Delivery. Health Canada has undertaken a number of new initiatives in the last three years, which we also reviewed.

We reviewed a status report by the Department on the action it has taken in response to our recommendations. We carried out extensive interviews with Health Canada staff involved in the administration of the *Canada Health Act* and with staff of the Department of Finance and the Privy Council Office. We also met with stakeholders and Health Canada staff in some regions. Finally, we reviewed documentation related to reported activities.

Our report presents the results of the areas that were re-audited.

Criteria

We expected that Health Canada would have made satisfactory progress in implementing our recommendations.

The criteria from the 1999 audit remain relevant. Therefore, we expected to find the following:

- a commitment to achieving consensus among the federal, provincial, and territorial governments on objectives, roles and responsibilities, and standards;
- a process for collecting and reporting information on performance; and
- a process for interpretation and enforcement of the *Canada Health Act* that is effective and transparent.

Ratings

We assessed the action of The Departments or Agency against our original audit recommendations (see Key Message at the beginning of the Chapter). We used the following ratings:

- **Completed.** Corrective action has been fully implemented
- **Satisfactory progress.** Progress is being made at a satisfactory pace
- **Limited progress.** Some progress is being made, but the pace or scope is not satisfactory
- **No progress.** No evidence of progress although the department or agency accepted the recommendation from the original audit
- **Rejected.** The department or agency did not accept the recommendation from the original audit
- **Unknown.** Status of progress is unknown or information is not available

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Chapter

4

National Defence
NATO Flying Training in Canada

The audit work reported in this chapter was conducted in accordance with the legislative mandate, policies, and practices of the Office of the Auditor General of Canada. These policies and practices embrace the standards recommended by the Canadian Institute of Chartered Accountants.

Table of Contents

Key Message 1

Introduction 3

Focus of the follow-up 3

Observations 4

The NATO Flying Training in Canada program 4

International participation is essential 4

National Defence states that the contractor is not providing the required levels of service in basic flying training Phase II 5

The program is not providing enough training flights per day to meet requirements 6

National Defence needed more instructors than originally planned 7

Problems and delays in the basic flying phase of the training program have caused shortfalls and cancellations in subsequent training phases 8

More pilots were awaiting training and were waiting longer 9

National Defence and PWGSC have been working on fixing problems for over two years but cannot say when problems will be resolved 9

National Defence has paid about $65 million for unused training capacity 9

About 79 percent of the contract fees are paid regardless of how many pilots are trained 11

Firm fixed payments are unconditional and irrevocable 13

National Defence has not yet determined whether it has under or over paid the variable fees to the prime contractor 13

Payments are not tied to performance 14

There are no mechanisms in the contract to allow for changes 15

The NATO Flying Training in Canada program did not include management practices consistent with a program of this size and risk 15

The program is slow in devolving a management framework to the users 16

National Defence is looking into new management arrangements for the program and lessons learned 17

Procurement Reform initiatives are underway but progressing slowly 17

Conclusion and Recommendations 18

About the Follow-Up 21

Appendices

A. Excerpts from our 1999 Report, Chapter 27, National Defence—Alternative Service Delivery 23

B. National Defence's pilot training process 25

C. NATO Flying Training in Canada program milestones 26

National Defence
NATO Flying Training in Canada

Assistant Auditor General: Hugh McRoberts
Principal: Wendy Loschiuk

Key Message

4.1 National Defence has entered into a $2.8-billion contract to train pilots over 20 years as part of the NATO Flying Training in Canada program. During the first two years of program implementation, National Defence used only about 41 percent of the training capacity that it paid for. Because of the restrictive terms of the contract and the problems encountered during start up, about $65 million in training costs were paid for training that was not obtained. The Department has informed us that there are contractual opportunities to recoup some of this expense. These opportunities need to be pursued now.

ORIGINAL ISSUES	PROGRESS	RATING*
4.2 The Treasury Board Secretariat should develop guidelines and training for large service contracts for multi-year terms as part of its continuing work on procurement reform.	In December 2001, we found that work on procurement reform had not addressed our concerns about partnering. The Treasury Board Secretariat's new policy on alternative service delivery provides some helpful guidelines, but is general in nature. Guidance on strategic direction and best practices in complex procurement has been completed and according to the Treasury Board Secretariat complementary training will be provided.	LIMITED PROGRESS

NEW ISSUES
4.3 National Defence did not train the contracted number of student pilots during the first two years of the NATO Flying Training in Canada program. In total, National Defence only used 41 percent of the training slots it paid for from February 2000 to December 2001. In spite of this, National Defence continued to pay its full fees for those years due to the nature of the contract. The total amount paid was $179.5 million for the right to use 355 training slots but National Defence used only 136 and sold off 10.
4.4 We are concerned that similar problems can occur in the future as the Department enters into other long-term support service contracts. In 1999 we reported to Parliament on two contracts for training that also showed the types of problems found in this follow-up.

*Possible ratings are completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Follow-Up for an explanation of the ratings.)

The Department has responded. National Defence agrees with most of our conclusions but feels that because of the unique nature of this program, many of the issues we raise were start-up challenges that were to be expected. Its responses, presented at the end of the chapter, elaborate on the actions it will take to address our concerns and recommendations.

Introduction

4.5 This follow-up on the NATO Flying Training in Canada program is an audit of National Defence's implementation and management of the $2.8-billion contract for a 20-year term for military pilot training. Our 1999 audit reviewed the contracting process up to the signing of the contract in May 1998. Pilot training was planned to start in February 2000. This follow-up reports on the results achieved during the first two years after planned start-up.

4.6 In 1999, we reported that the contract was awarded without competition, that the profit mark-up was not consistent with current Government of Canada guidelines or supported by adequate analysis of contractor risk, and that the chosen financial arrangements increases some risks (Appendix A). Departmental officials responded that a major advantage of moving to a training system supported by a contractor was the shifting of risk to the contractor. However, they had not quantified this risk before awarding the contract.

4.7 In our December 2001 follow-up report on National Defence—Alternative Service Delivery we reported that National Defence had changed its approach to alternative service delivery projects and that employee training was now available. We mentioned that National Defence did not address alternative service delivery projects in its Report on Plans and Priorities and that the government's work on procurement reform had failed to address our original concerns about large service contracts for multi-year terms.

4.8 This follow-up focusses on the NATO Flying Training in Canada program. We assessed whether National Defence had used the levels of service paid for from February 2000 to December 2001 and whether it had received value for money. As well, we followed up on our 1999 recommendations to the Treasury Board Secretariat and Public Works and Government Services Canada's continuing work on procurement reform.

Focus of the follow-up

4.9 The objectives of this follow-up were to report to Parliament on the implementation and management of the NATO Flying Training in Canada contract from February 2000 to December 2001. During the contracting process, the Department determined how many pilots would be trained by the system for the next 20 years. We did not audit the planning process or the numbers that were agreed to by the Department. Rather, our audit examined whether National Defence used the services that it paid for and whether it obtained value for money.

4.10 We did not audit the activities of the prime contractor. Our audit was limited to National Defence, Public Works and Government Services Canada, and the Treasury Board Secretariat. We reported facts regarding contract delivery, but limited our comments and observations to whether the actions of the government were appropriate. Further details can be found in About the Follow-Up at the end of the chapter.

Observations

The NATO Flying Training in Canada program

CT–156 Harvard II aircraft used for Phase II basic flying training.

CT–155 Hawk aircraft used for Phase III advanced and Phase IV fighter lead-in training.

4.11 The program provides flying training to military student pilots to fly the Canadian Forces' helicopters, multi-engine aircraft and the CF–18 Hornet jet fighters. The program trains pilots who have already passed primary flying training by offering four additional phases of training—basic Phase IIA, basic Phase IIB, advanced Phase III, and fighter lead-in training Phase IV (Appendix B). The first three training phases are taught at Moose Jaw, Saskatchewan and fighter lead-in training is taught at Cold Lake, Alberta. Those who will fly the CF–18 Hornet take all four phases of the program. The pilots who will fly helicopters and multi-engine aircraft go on to a separate training program in Portage la Prairie after they graduate from basic flying training Phase IIA.

4.12 The Harvard II aircraft is used for basic flying training. The Hawk aircraft is used for advanced Phase III and fighter lead-in training Phase IV.

4.13 As the prime contractor, Bombardier Inc. co-ordinated start-up activities with several international firms. The prime contractor is responsible for providing and supporting aircraft and simulators. They also provide ground school training for phases IIA, IIB, and III in Moose Jaw, classroom training systems, and maintenance services. The prime contractor provides the aircraft by leasing them for the life of the program from a not-for-profit company created at the start of the NATO Flying Training in Canada program.

4.14 National Defence and the prime contractor share some responsibilities: design of ground school training, scheduling of student facilities and aircraft, and the provision of operational and base support services.

4.15 National Defence is responsible for overall program management including operational control of training, providing instructors for flight training, providing infrastructure and military flying training areas at Moose Jaw and Cold Lake, and for the design, development, and conduct of flying training. It is also responsible for ground school training for the fighter lead-in phase, quality assurance, and student administration.

4.16 National Defence selected this as an alternative to training its pilots on the aging Tutor aircraft. It was one of three options for training pilots that the Department studied in the early 1990s (Appendix C). The other two options were to either purchase fighter pilot training off-shore or to upgrade the Tutors and extend the original program.

International participation is essential

4.17 Government approval of the program depended on the participation of other nations to help offset the costs of new aircraft and simulators. Without international participants, National Defence would be responsible for all the costs of the program. The government directed that the established fees charged for foreign participants would be on a full cost recoverable basis. As of December 2001, Canada and the air forces of four other countries were

participating in the program—Denmark, the UK, Italy, and Singapore. The Hungarian Air Force has also signed on to the program and will start training pilots in 2002.

4.18 National Defence and the participating countries pay for a specified number of training slots each year. For example, National Defence has contracted for 141.6 Phase IIA basic flying training slots each year. In addition, other nations have purchased training slots based on the number of years they have committed to the program. The levels of service the prime contractor is required to provide are spelled out in the various contracts and agreements under the program (Exhibit 4.1).

Exhibit 4.1 NATO Flying Training in Canada program, 2001

Canada	20	141.6	22	32	20.2[2]
Denmark	20	6	5	5	5
Italy	20	3	3	2	2
Singapore	20	0	0	6	4
United Kingdom	10	0	0	2	20
Total Starts		**150.6**	**30**	**47**	**51.2**

[1] Years that the country has committed to participate in the program.

[2] Canada bought 24.2 training slots and in 2001 sold 4 to other countries as part of a long-term sale; 20.2 slots remained.

Source: Canada Services Agreement amendments

National Defence states that the contractor is not providing the required levels of service in basic flying training Phase II

4.19 During the first two years of the program (from February 2000 to December 2001), National Defence states that it was only able to use 105.4 of the 265.6 Phase IIA basic flying training slots it purchased, or 40 percent. It was expected that during this time National Defence would have graduated about 216 student pilots from Phase IIA (assuming 15 percent attrition). Due to delays and cancellations, the expected graduation numbers were revised to 160 Canadian pilots but by December 2001 only 61 Canadian student pilots graduated from this phase of the program. Many that should have finished in 2001 will now finish in 2002.

CT–114 Tutor aircraft used for pilot training prior to the NATO Flying Training in Canada program.

4.20 Prior to January 2000, the Canadian Forces trained its own pilots on the Tutor aircraft. Once the NATO Flying Training in Canada contract was signed, the Department decided to shut down its existing program prior to the start-up of the NATO Flying Training in Canada program. The Tutor training

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Country	Years committed[1]	2001 Training Phase Capacity Bought			
		Basic Phase IIA	Basic Phase IIB	Advanced Phase III	Fighter lead-in Phase IV
Canada	20	141.6	22	32	20.2[2]
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system had produced 64 basic flying training graduates in one year (1999) from an intake of 78 students. By December 2001, the NATO Flying Training in Canada program had not reached this level of performance after two years of operation and when National Defence is short of pilots for its helicopters, multi-engine, and fighter aircraft.

4.21 The first four courses of the NATO Flying Training in Canada program were originally scheduled to start between February and May 2000, but were cancelled because of late delivery of the aircraft and simulators. Problems in acquiring the Harvard II aircraft and technical data from the United States due to International Trade in Arms Regulations (ITAR) issues, aircraft engine problems, and certification problems with the aircraft and aircraft maintenance operation meant that the program did not start training students until June 2000.

4.22 In August 2000, two months after basic flying training had started, a problem with the engine oil cooler caused National Defence to ground the Harvard II aircraft because of concerns about pilot safety. Training was delayed for three more months until the problem was fixed and one course was cancelled.

4.23 In 2001, three more courses were cancelled. Overall 8 of the 17 courses planned for 2000–01 were cancelled and only 3 of the 9 courses that did take place were fully loaded with the contracted number of students (16). Furthermore, courses which should have been completed in 5 to 7 months took on average about 9 to 10 months to complete (Exhibit 4.2).

Exhibit 4.2 NATO Flying Training in Canada: Basic flying training Phase IIA courses (February 2000–December 2001)

	Courses		
	Planned	**Cancelled**	**Actual**
2000	8	5	3
2001	9	3	6
Total	**17**	**8**	**9**

Source: National Defence

4.24 The student intake for 2002 has been reduced to 105 students overall, about 41 below the contracted course-load level, in order to match students and available training capacity.

The program is not providing enough training flights per day to meet requirements

4.25 The contract states that on average 81 sorties, or training flights, could be scheduled each day by National Defence so that pilots can complete their flying training on schedule and move on to the next phase as planned. The prime contractor is responsible to provide and maintain enough aircraft and

system had produced 64 basic flying training graduates in one year (1999) from an intake of 78 students. By December 2001, the NATO Flying Training in Canada program had not reached this level of performance after two years of operation and when National Defence is short of pilots for its helicopters, multi-engine, and fighter aircraft.

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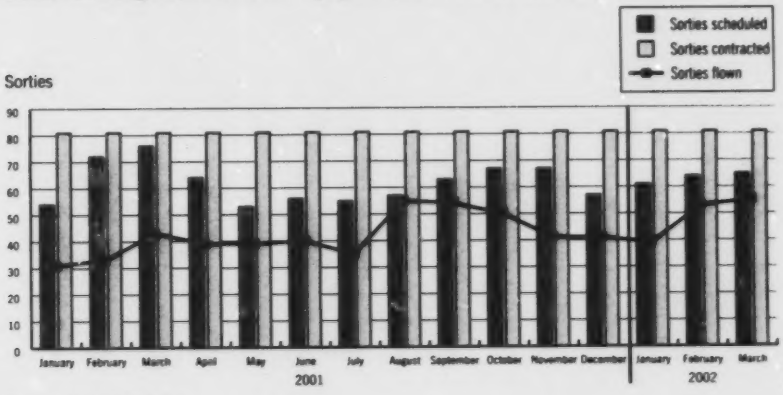
simulators to meet the specified sortie rates. Departmental analysis showed that 17 serviceable aircraft flying five flights per day must be available to generate this rate of flying activity. However, on average only 14.5 serviceable aircraft have been available during the first two years of the program to maintain the sortie rate.

4.26 Throughout 2001 National Defence did not receive the contracted sorties to meet its demand. Since the program has been in operation, National Defence has only scheduled an average of 62 sorties per day and has only flown an average of 42 sorties per day. Although there has been some improvement, the actual number of sorties flown per day is still far below anticipated levels and therefore the backlog continues to grow (Exhibit 4.3).

Exhibit 4.3 Average sorties at the basic flying level with the Harvard II aircraft



Source: National Defence

4.27 According to the Department, aircraft availability has been an ongoing problem and has resulted in training delays and cancellations. Departmental documents indicate that most of the problems with the program over the first two years of operation relate to Harvard II aircraft availability. The Department has stated that the focus is on problem-solving rather than attributing blame and has worked closely with the prime contractor to get the most training possible under current circumstances.

National Defence needed more instructors than originally planned

4.28 In 2001, studies conducted by the flight schools in Moose Jaw and Cold Lake found that the number of instructor pilots provided by National Defence was enough to meet the initial planned staffing levels, but this initial number was not adequate to meet the training demand. The flight school in Moose Jaw has recommended increasing the number of instructors to 80. In early 2002, the Canadian Forces took action to remedy the shortage by increasing the number of instructor pilots at Moose Jaw from 60 to 71 but a decision of the final level of staffing remains outstanding.

The CF-18 Hornet fighter aircraft.

Problems and delays in the basic flying phase of the training program have caused shortfalls and cancellations in subsequent training phases

4.29 Overall, the start-up challenges in the basic flying training phases have meant that National Defence has been unable to use the full capacity in the advanced and fighter lead-in training phases.

4.30 **Advanced training Phase III.** The Department identified that advanced flying training would be underused throughout 2001 since delays in basic flying training meant that no students were ready to start the advanced work.

4.31 By December 2001, National Defence had used only 8 of the 29 basic flying training Phase IIB positions it purchased and only 13 of 36 advanced Phase III slots. In 2001, Canada sold 5 Phase III slots that they could not use to the United Kingdom and Italy. On average advanced courses have been one month longer than planned and one course was cancelled in 2001.

4.32 **Fighter lead-in training Phase IV.** The first course was cancelled because of delays in delivering the Hawk aircraft and simulator, and preparing the course material. However, the next three courses ran with more students than originally planned to make up for the cancelled course. These students had not completed Phase IIA or Phase IIB of this training program but were either previously qualified Canadian pilots being retrained to fly the CF–18 Hornet or international students.

4.33 One critical shortfall that was identified by National Defence in March 2001 was the late delivery of the centre line fuel tank for the Hawk aircraft, an external fuel tank which increases the range of the aircraft and is required for fighter lead-in training. The fuel tanks were late being built and once they were received, the Department needed eight months to complete certification test flights. This meant that the course syllabus had to be adjusted with shorter training flights. In some cases this lack of equipment extended the course by as much as two to three weeks beyond the planned graduation date. At the end of March 2002, the centre line tank was cleared for use and has now been installed on the fleet.

4.34 By December 2001, National Defence had sold off 4 Phase IV slots to Denmark and Singapore, reducing its capacity to 20.2. National Defence used only 5 of its remaining 20.2 slots in the fighter lead-in training phase and had sold off 5 additional slots to the United Kingdom and Italy. The Canadian pilots that did graduate from Phase IV had actually received their basic training on the Tutor aircraft. As the program grows, by 2004 National Defence will have 29 Phase IV training slots, but projections to 2004 indicate that National Defence is only going to use 9 slots per year and continue to sell 6 which would leave 14 slots unused. The first Canadian pilot to be trained from Phase IIA to Phase IV through the NATO Flying Training in Canada program is scheduled to graduate in July 2002.

More pilots were awaiting training and were waiting longer

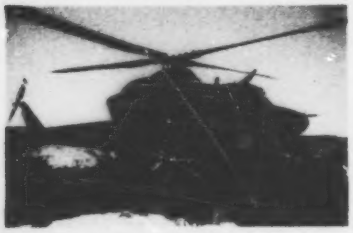
4.35 The number of Canadian pilots awaiting training and the wait time for training has increased. In September 2001, 161 students were awaiting basic flying training. Behind this group were another 109 candidates completing basic officer training, second-language training, or initial degree requirements whose names would be added to the pilot training waiting list. On average, students were waiting 18 to 22 months before starting pilot training.

4.36 The Department has indicated that in July 2002, the number of Canadian pilots awaiting training had decreased to 131 and the average waiting time had fallen to 14 months. They expect this trend to continue.

CC130 Hercules Transport aircraft.

4.37 National Defence has stated that the operational impact has been manageable since the system was producing as many pilots as could be accepted into the helicopter and the multi-engine aircraft school or the various operational training units. Nevertheless, departmental documents show the situation was difficult for the students facing delays and frustrating for persons involved in the program.

National Defence and PWGSC have been working on fixing problems for over two years but cannot say when problems will be resolved



CH–146 Griffon helicopter.

4.38 National Defence and Public Works and Government Services Canada (PWGSC) have identified a number of problems with implementing the contract. They are working with the prime contractor to fix them. For example, a steering committee, co-chaired by National Defence and the prime contractor was set up to address issues like the low sortie rates. However, many of the issues identified early in the program have yet to be resolved.

4.39 The contract gives National Defence the right to sell some of its unused training capacity to other countries under a memorandum of understanding. Fees from these sales help offset some of the fixed cost to the Department. However, the contract limits the number of slots that can be sold. National Defence can only sell off 11 basic, 15 advanced and 15 fighter lead-in slots per year. The prime contractor nevertheless has waived this contractual limit during the time frame of the follow-up in order to allow National Defence to sell 20 slots to Hungary that cannot be used because of production delays in the basic flying phase. This enables the Department to recoup some of its costs.

National Defence has paid about $65 million for unused training capacity

4.40 National Defence has not used the full amount of training purchased in any phase of the program. From the start of the program to December 2001, National Defence only used 41 percent of the planned student slots but still paid most of the anticipated cost (Exhibit 4.4).

4.41 National Defence has paid a total of $179.5 million, which includes costs for both students and instructors, of the anticipated $206.8 million training costs.

Exhibit 4.4 National Defence student use and cost of the four training phases

Phase	Contractual starts	Actual starts	Sold to other countries	Use (%)	Contract costs ($ millions)	Actual costs ($ millions)	Cost (%)
Basic (IIA)	265.6	105.4	0	40	45.4	45.7	100
Basic (IIB)	29.0	8.0	0	28	1.5	1.5	100
Advanced (III)	36.0	13.0	5	50	15.7	14.9	95
Fighter lead-in (IV)	24.2	9.0	5	58	8.3	8.1	98
Total	**354.8**	**135.4**	**10**	**41**	**70.9**	**70.2**	**99**
Total costs[1]					206.8	179.5	87

[1] Including costs for training instructor pilots and firm fixed fees.

Source: National Defence, 2002

4.42 National Defence calculated a cost per student for the foreign participants based on the target capacity of the program. If the program had been operating at its total capacity during the first two years, National Defence would be paying the same per student as other nations. During the first two years of the program, we estimate that National Defence paid about $65 million for training that it did not use. International participants are using all of the training slots they bought while Canada is not. This means that National Defence is paying the financial impact of inefficiencies in the program and the lack of productivity in Phase II (Exhibit 4.5).

4.43 In some cases, the minimum amount of equipment which the program needs has residual capacity that can train more students as the program expands, for example; the simulators for the Hawk aircraft. Because foreign fees were based on participants paying a fair share of equipment total capacity, until the program expands Canada is absorbing this as a business risk which the Department hopes to recover in the future. As well, Canada pre-pays the fees in advance of the training program reaching its full capacity. As of December 2001, the value of these two factors was estimated to be about $25 million (Exhibit 4.5). However, the department feels that as the program reaches full capacity, much of this value will be recouped. The final result will depend on how much the program finally expands.

4.44 In our 1999 report on Alternative Service Delivery, we found that inflexible contract arrangements resulted in payments for unused training capacity at the Meaford Area Training Centre and the Canadian Aviation Training Centre. For example, the Meaford Area Training Centre operated under a $40 million, five-year, fixed price contract and had used only 43 percent of its capacity. The Canadian Aviation Training Centre flying training program at Portage La Prairie, operating under a $165 million contract, was consistently underused during the first six years of operation.

Exhibit 4.5 Costs and value of unused capacity for the NATO Flying Training in Canada program

Estimated costs based on starts and costs of the Canada Services Agreement (CSA)	($ millions)
Cost of training students	111
Cost of instructor pilots	15
Total	**126**[1]
Actual level of output	**($ millions)**
Canadian student pilots trained	43
Canadian instructor pilots trained	13
Slots sold to foreign countries	5
Total	**61**
Value not received due to under use of the program	**65**[1&2]
Actual costs of the program to Canada	**($ millions)**
Actual amount that Canada has paid to the contractor	190
Revenues from foreign countries	39
Actual costs of the program to Canada	**151**[3]
Less estimated cost of the program	(126)
Difference between estimated and actual cost of the program	**25**[4]

Notes: The costs reflected in this calculation do not include other operational or personnel costs incurred by National Defence, such as pilot salaries and overhead.

1 The firm fixed fee used in estimating the CSA cost of training students and instructors and in calculating the value of actual output of Canadian student pilots and instructors was taken from foreign fee rates; the fee included an element of transition cost repayment.

2 Estimated value of the Canadian training slots that were actually used and the value of slots that were sold to foreign countries since they could not be used by Canada.

3 Actual costs for Canada and foreign revenue does not include approximately $18 million in variable and cost reimbursable fees, paid to the contractor, a portion of which should eventually be returned when the reconciliation process is complete.

4 Estimated value of program overhead (for example, simulator time) that was not used in the first two years of operation. Canada will continue to absorb costs for this additional capacity.

About 79 percent of the contract fees are paid regardless of how many pilots are trained

4.45 National Defence pays tuition fees to the prime contractor for the services detailed in the contract. Tuition fees are based on a schedule of payments in the contract and are composed of fixed and variable fees. About 79 percent of the total $2.8 billion cost of the program covers overhead and equipment costs and is fixed. This amount must be paid no matter how many pilots are trained. The remaining 21 percent of the fees are variable and are based on the actual number of pilots trained and their use of the aircraft and supplies. The contract also calls for National Defence to pay transition fees to the prime contractor for work done before the program was implemented (Exhibits 4.6 and 4.7).

Exhibit 4.4 National Defence student use and cost of the four training phases

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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Exhibit 4.6 Fee structure for the NATO Flying Training in Canada program

Fixed fees

Fixed fees cover program expenses for the delivery of training services and are payable whether or not National Defence uses the contracted amount of training capacity. There are two types of fixed fees:

- **Firm fixed fees.** Firm fixed fees are used to obtain the assets such as aircraft, simulators, the provisions needed to start the program, and the initial set up costs. These fees are fixed for the duration of the program.
- **Firm fees.** Firm fees are related to the cost of running the airport at Moose Jaw, providing and maintaining all the program's infrastructure, operating the ground school and providing the simulator instruction, providing aircraft maintenance, and contractor program management, and insurance. These fees are firm for the length of the program but are adjusted for inflation and changes in currency exchange rates.

Variable fees

Variable and cost reimbursable fees are based on actual student pilot usage and are supposed to be adjusted every six months.

- **Variable fees.** Variable fees relate to actual use of the aircraft to cover the cost of consumable spare parts. A rate per flying hour has been set and this is charged based on the actual flying time of each student and instructor. Countries prepay an estimated amount which is later adjusted based on actual usage. This hourly rate has been set for the contract but is adjusted based on inflation.
- **Cost reimbursable fees.** These fees are for the actual use of petroleum and oxygen consumed during the program. Like the variable fees, participants prepay an estimated amount which is then later adjusted based on actual usage.

Transition fees

Transition fees cover the cost of transferring the operation of the base to the prime contractor and upgrading the original facilities to meet the new program requirements.

Source: National Defence, April 2002

Exhibit 4.7 Basis of payment over the 20-year contract period

Type of payment	Amount ($ millions)	Percentage
Transition fees	46.5	1.8
Firm fixed fees	1,258.1	47.8
Firm fees	808.8	30.7
Variable fees	417.0	15.8
Cost reimbursable fees	103.6	3.9
Total	**2,634.0**[1]	**100.0**

[1]The contract totals $2.8 billion including the GST.

Source: National Defence, April 2002

Firm fixed payments are unconditional and irrevocable

4.46 A non-share, not for profit corporation was established to purchase equipment for the NATO Flying Training in Canada program. It issued a $720 million bond to obtain the capital required to buy the aircraft and simulators.

A student undergoing training in a flight simulator.

4.47 National Defence must make 40 semi-annual payments of $31.4 million over 20 years (December 1999–June 2019) which go to the not-for-profit corporation to cover the cost of the principal and interest on these bonds and its operating costs. These payments are unconditional and irrevocable regardless of whether National Defence has the use of the aircraft. National Defence must pay even if the prime contractor is placed in default and the contract is terminated. However, should this occur, National Defence would continue to have access to the aircraft.

4.48 In December 1999, National Defence paid $31.4 million but the aircraft were late in being delivered and, therefore, could not be used for training. National Defence cannot recover this payment despite the late delivery of the aircraft. There are provisions in the contract to ensure that National Defence retains access to the aircraft and simulators if the program is extended to provide the missed training. However, it is not clear at this point whether National Defence will have to pay some of the expenses necessary to keep the aircraft or whether this is the responsibility of the prime contractor. At the end of the program, the licence agreement states that National Defence can purchase the aircraft at fair market value.

4.49 In addition, National Defence paid the prime contractor $15 million in firm and variable fees to meet its contractual obligations even though the first four courses had to be cancelled. The contract required that National Defence pay these fees as per the agreed schedule. The prime contractor has returned $2.5 million of the $15 million advance payment, the pre-paid variable components of the fees, since no students were trained.

4.50 The contract does state that training not provided can be made available at some future date. The contractor is willing to provide the training but, until it does, it has been paid $12.5 million for training that has not yet been conducted. As well, problems with program delivery must be resolved first in order to clarify how the provisions in the contract will apply.

National Defence has not yet determined whether it has under or over paid the variable fees to the prime contractor

4.51 National Defence makes semi-annual prepayments for variable and reimbursable fees based on an estimated amount of consumption. These fees are to be adjusted at regular six month intervals based on actual use. To date, this has not been completed. National Defence and the prime contractor have yet to finalize the number of flying hours used.

4.52 National Defence has paid $44.2 million to the prime contractor in variable and reimbursable fees of which almost $11 million is for international participants. It has not used all of the training slots and is entitled to a refund

for these advanced payments. National Defence is still reviewing a proposal from the prime contractor for a refund of $6.6 million for the training period from 1 January 2001 to 30 June 2001. This number remains in dispute.

4.53 The contract states that the prime contractor will provide an information management system, but this has not yet been put in place. As a result there have been delays in finalizing the reconciliation, since all records must be reviewed and accounted for manually. In September 2001, the contractor and program participants agreed to change the method of reconciliation. National Defence personnel on site in Moose Jaw who were expected to provide the input for the reconciliation were not trained in the process. Until the reconciliation of flying hours has been finalized, National Defence cannot determine whether it has under or over paid the prime contractor for these fee elements.

4.54 The agreements with the other countries involved with the NATO Flying Training in Canada program require a similar type of reconciliation at regular six month intervals. Since National Defence has not reconciled with the prime contractor, it cannot reconcile variable fees with the other nations. The result is that National Defence does not know if it has over or under charged other nations for the training that they have received.

Payments are not tied to performance

4.55 National Defence's payments under the contract are based on schedules rather than performance milestones. In the event that the prime contractor is non-compliant with the terms of the contract or where the prime contractor does not provide the specified levels of service, there are no financial incentives that can be used by National Defence. Conversely, there are no performance incentives to reward or encourage the prime contractor for exceptional service.

4.56 The only remedy available to National Defence under the contract would be to place the prime contractor in default of the contract. Short of putting the contractor in default, National Defence may not withhold payments regardless of the quality or quantity of the service provided. A National Defence study of the Alternative Service Delivery program (May 2001) concluded that for the NATO Flying Training in Canada program "the only real financial incentive [to ensure that the prime contractor provides full delivery of services] is the threat of termination of the contract."

4.57 Although the NATO Flying Training in Canada program has been providing training to students since June 2000, the prime contractor and National Defence have never reached an agreement as to how they will measure the performance. There is still a disagreement between the parties as to what constitutes availability of the aircraft. While the prime contractor may have the required number of aircraft operational on a particular day, factors such as slow turnaround of the aircraft may cause the schedule to slip such that it results in the cancellation of sorties. These missed sorties lead to

differences between the required and actual number of sorties provided and it also raises questions as to the level of contractual compliance. This issue has been outstanding since the beginning of the program and while progress has recently been made, there is still no agreement on what constitutes successful performance by the prime contractor.

There are no mechanisms in the contract to allow for changes

4.58 Unlike many standard government contracts, this contract does not include any specific clauses describing allowable ways to change the contract. Even though it is not possible to foresee all situations that may occur, particularly given the long-term nature of the agreement, we would have expected the contract to include a clause that would outline the procedures for implementing changes. The personnel of Public Works and Government Services Canada that are involved in the management of the contract have recognized the need for a change process. They have begun work on getting an agreement to outline a procedure for changes to the contract.

4.59 In its 1999 report on *Examining the Value for Money Deals under the Private Finance Initiative*, the United Kingdom National Audit Office states that in long term contracts, "change is inevitable as the Department's needs and priorities will alter over time." The program does allow for some adjustment by selling training capacity between countries and drafting of memoranda of understanding, but any contract changes would involve re-negotiations.

The NATO Flying Training in Canada program did not include management practices consistent with a program of this size and risk

4.60 The government recognizes the risk associated with managing large, complex projects and has a policy in place to identify and manage them. Projects that exceed $100 million and that are assessed as high risk are considered major crown projects. The NATO Flying Training in Canada program is a complex project valued at about $150 million per year for 20 years. Although the NATO Flying Training in Canada program exhibits many characteristics that are common to major crown projects, it was not managed as one. Treasury Board Secretariat officials told us that, at the time, the policy was only applied to capital acquisitions while this project was considered to be a service delivery contract. It was subject to a high-level of management reporting and oversight.

4.61 Nevertheless, due to similar characteristics, we expected to find similar management practices as part of this program's initial governance arrangements, such as an integrated risk management process and a performance measurement system. As a result of some of the difficulties realized during the first two years of implementation, Public Works and Government Service Canada officials have now brought in some of the management structures described in the Treasury Board Manual section on major crown projects.

4.62 The staffing and personnel requirements for the program were based on the assumption, made in the absence of a satisfactory risk assessment, that the contract was a routine service contract, despite its large dollar value and multi-year nature. The program was not given the same level of resources that a major crown project would receive. Public Works and Government Services Canada have recently hired a person to act as the local contract officer in Moose Jaw and provide a link between the site and the project office.

The program is slow in devolving a management framework to the users

4.63 Administration of the contract and dealings with the prime contractor have been centralized in the project management office at National Defence. The program was planned so that the operation would be producing the contracted levels of service by February 2002. However, given the number of outstanding contractual issues that have not been resolved the project management office will remain in place for an additional two-year period.

CT–155 Hawk and CT–156 Harvard II aircrafts.

4.64 The 15 Wing Moose Jaw 2002 business plan identifies the lack of a clear governance and accountability chain to allow timely decision making and effective management. Until very recently, limited information or decision-making authority have been devolved to the local training personnel, even though they are the ones who have to deal with prime contractor on a daily basis and are responsible for ensuring that the program meets the needs of the students. It also identifies constraints on their ability to plan and operate effectively, including shortfalls with the NATO Flying Training in Canada program and contract and misunderstandings with the prime contractor, such as

- the command and control structure is too complicated,
- there is not a clear understanding of responsibilities, and
- there is a lack of visibility of available resources which has resulted in cumbersome and protracted planning and decision making cycles.

4.65 Officials of National Defence and Public Works and Government Services Canada have recently started developing a governance and accountability framework as part of the NATO Flying Training in Canada program's transition to the steady state level of operations. Public Works and Government Services Canada has created a director level position to oversee the project. This has assisted in bringing some major issues to the foreground.

4.66 In an internal departmental study released in April 2002, National Defence identified many of the issues being reviewed in this audit, specifically

- no single point of accountability for the program,
- poorly defined roles and responsibilities with no person or position clearly responsible for dealing with unique governance issues,
- lack of communication between all levels and slow response to local base concerns,
- disjointed or non-existent business planning,

- lack of understanding of prime contractor responsibilities,
- a limited number of personnel who understand the terms of the NATO Flying Training in Canada contract,
- lack of skilled personnel to address contracted service problems,
- lack of succession planning, and
- poor Air Force control over the pilot production process.

4.67 The report does note some strengths of the existing program, including the strong central control and effective contract management performed by the project office, and the benefits of co-locating the technical authority, contract management and Public Works and Government Services Canada personnel within the same office.

National Defence is looking into new management arrangements for the program and lessons learned

4.68 There are various governance studies currently under development within National Defence which have identified particular concerns with the management and accountability framework. These governance studies come well into the third year of operation of the program. We expected that the project team would have had a plan to guide the transition to the steady state level of operations. Still, we are encouraged that National Defence and Public Works and Government Services Canada are addressing these issues at this time.

4.69 Given the unique structure and the creative approaches used in the provision of services under this agreement, there is increased risk for the Department but also a significant opportunity for learning and innovation. Since National Defence is looking to enter into similar agreements in the near future with the re-tendering of flight training services at Portage La Prairie and other service contracts, we expect that the lessons learned from the NATO Flying Training in Canada program would be documented for use both across the department and across government. However, formal lessons learned have not yet been recorded on this project either by National Defence or Public Works and Government Services Canada.

4.70 National Defence has recently started work on a major service delivery framework. Although this initiative is in the early stages of development, the aim is to provide a framework for large-scale contracts for the delivery of complex services. Its purpose is to provide National Defence with easy access to sources of information and set the stage to develop and use an integrated set of policies, procedures, processes, and tools.

Procurement Reform initiatives are underway but progressing slowly

4.71 In our 1999 Report, we recommended that, as part of its on-going work on procurement reform, guidelines and training be developed for large multi-year service contracts and that these should address key issues of how competition is to be addressed where long-term "partnering" would be beneficial to the government. In 1999, the Treasury Board Secretariat

indicated that they were developing a guide and a database on alternative service delivery. The Treasury Board Secretariat was also leading an interdepartmental initiative on procurement reform, which would include guidance for large, multi-year service contracts. Public Works and Government Services Canada also indicated that they would be working with the Treasury Board Secretariat in this regard.

4.72 In our December 2001 follow-up on alternative service delivery we reported that the Treasury Board Secretariat, Public Works and Government Services Canada and National Defence were working on a framework and best practices guide on long-term complex contracts. They have recently completed a paper on Strategic Direction and Best Practices in Complex Procurement. The paper documents the strategies and techniques that have been developed by Public Works and Government Services Canada and National Defence on dealing with an increasingly complex procurement environment and Treasury Board Secretariat officials said that it will be used as a guide for future procurement.

4.73 In April 2002, the Treasury Board Secretariat released a new Policy for Alternative Service Delivery. While the new policy provides some limited guidance on the governance and performance monitoring for alternative service delivery projects, it provides little direction for long term, large dollar value service arrangements. The planned alternative service delivery database is not yet operational.

4.74 Public Works and Government Services Canada is developing a training course covering complex procurement. Department officials informed us that the program has been piloted and is nearing completion of the development phase.

Conclusion and Recommendations

4.75 National Defence did not train the contracted number of student pilots for which it paid in the NATO Flying Training in Canada program. During the first two years of this program it used only 40 percent of the basic Phase IIA flying training slots, 28 percent of the basic Phase IIB training, 50 percent of the advanced Phase III training and 58 percent of the Phase IV fighter lead-in training for which it has contracted. We estimate that as of the end of December 2001, the Department had paid about $65 million more than the value of training received. This amount is growing and will continue to grow as long as the program remains underutilized.

4.76 National Defence recognizes that it has had program management problems. Studies are underway to determine how best to manage the NATO Flying Training in Canada program but there are outstanding issues that must be resolved. Developing a solid governance arrangement is the first step in improving overall management.

4.77 **Recommendation.** The Department should resolve the program management issues and implement a revised management framework as a matter of urgency.

National Defence's response. The Department will continue to evolve the governance structure to meet complex needs and a steady state structure will be put in place over the next year. NATO Flying Training in Canada is a unique and complex program being managed in a constructive and evolutionary fashion. There has been significant oversight at senior management levels from two government departments during the difficult start-up period. Now responsibilities are being slowly, carefully, and appropriately delegated to various levels within both the Department and Public Works and Government Services Canada. Although there has been much discussion and some differences of opinion over the program's steady state governance structure, we maintain that identifying and then resolving issues reflects an appropriate management approach.

4.78 We have reported on underused training capacity in the past and have concerns that problems may be repeated as new contracts are negotiated. This program does not have the flexibility needed in long-term contracts to accommodate changing needs over time or the measures to ensure performance meets expectations.

4.79 **Recommendation.** Lessons learned from the NATO Flying Training in Canada program should be documented and reported to senior management with an action plan.

National Defence's response. The Department agrees that formal documentation of lessons learned is important. Moreover, lessons learned in the NATO Flying Training in Canada Program are already being applied in real-time to the Contracted Flying Training and Support project that is being managed within the same project office. The Department's intent is to formally document all applicable lessons this fiscal year and then promulgate them through appropriate media.

4.80 **Recommendation.** New contracts of a similar nature to the NATO Flying Training in Canada program that the Department enters into should ensure that

- payments are tied to performance and value received, and
- a project management framework commensurate with the risk and design of the program is in place at the outset.

National Defence's response. It is unlikely that many of the unique risk-sharing features of the NATO Flying Training in Canada contract will arise in the foreseeable future. However, as was the case with this particular contract, the Department will continue to tailor project management structures and contract terms and conditions to the unique circumstances of each contractual arrangement.

4.81 **Recommendation.** The Department should ensure that the services purchased through a long term service contract are aligned with the ability to use them.

National Defence's response. The Department agrees that this is an appropriate goal but disagrees with the implication that this was not the case with NATO Flying Training. We believe that the under utilization of capacity observed by the Office of the Auditor General was a reflection of the challenges inherent in starting up a new program of this magnitude and complexity. The Department remains confident that purchased training capacity will be more fully utilized in future as the program matures. In the NATO Flying Training program, the possibility of reduced training demand over time was considered and there is a contractual provision for Canada to sell off 50 percent of our "jet pilot" training capacity to other nations. Further, since the NATO Flying Training in Canada program was designed to be marketed, there is a built-in marketing infrastructure to dispose of non-required capacity should that occur.

National Defence's comments. The NATO Flying Training in Canada Program is a unique program of risk-taking and risk-sharing, which, despite some start-up hurdles that are being overcome, represents a huge leap forward in training technology and training philosophy. The Department agrees that training production in Phase II has been less than expected in the first two years, but asserts that any missed training will be made up later in the contract. The contractor has an obligation to make up all the contracted training over the life of the program and the contract is being enforced.

This program represents the best long-term option for the training of Canada's military pilots. NFTC is a success with over $1 billion of training sold internationally. NFTC is now the recognized benchmark against which future pilot training systems are being compared.

About the Follow-Up

Objectives

This follow-up audit had two objectives:

- to examine the implementation and management of the NATO Flying Training in Canada program and to determine whether the service contract was meeting the needs of the department in an economical and efficient way, and
- to review whether the Treasury Board Secretariat and Public Works and Government Services Canada had made any progress in responding to our recommendations about procurement reform and "partnering" as stated in the 1999 chapter on alternative service delivery chapter.

Scope

Our audit focussed on the management framework and processes with respect to the NATO Flying Training in Canada program in place at National Defence, the Canadian Forces, 1 Canadian Air Division and the Canadian Aerospace Training Program office. In addition, it looked at the management and delivery of contracted services at 15 Wing, Moose Jaw, and 4 Wing, Cold Lake.

We assessed the implementation and management of the NATO Flying Training in Canada program from the time the contract was signed in May 1998 until March 2002. This represents a very short period in the overall life of the 20-year contract worth $2.8 billion. While our audit focussed on this time period, we have made certain comments about the way the planning was done in the pre-contract stage.

We also focussed on work done to date by the Treasury Board Secretariat and Public Works and Government Services Canada on implementing our 1999 recommendations.

We did not audit the activities of the prime contractor and, as a result, do not comment on them. We do bring forward facts regarding their activities but limit our comments to the whether the actions of government officials were appropriate or not.

Criteria

We followed up on the recommendations for procurement reform made to the Treasury Board Secretariat and Public Works and Government Services Canada in our 1999 audit on alternative service delivery.

We expected that National Defence would ensure that the goods and services contracted for would be delivered as stated in the contract. We expected that National Defence would act in a way compatible with the *Financial Administration Act* to ensure that only money earned is paid.

We also expected that the Canadian Forces would be able to train the number of pilots required as indicated in the contract in a cost-effective way.

Ratings

We assessed the action of departments/agencies against our original audit recommendations (see Key Message at the beginning of the chapter). We used the following ratings:

- **Completed.** Corrective action has been fully implemented.
- **Satisfactory progress.** Progress is being made at a satisfactory pace.
- **Limited progress.** Some progress is being made, but the pace or scope is not satisfactory.
- **No progress.** No evidence of progress although the department or agency accepted the recommendation from the original audit.
- **Rejected.** The department or agency did not accept the recommendation from the original audit.
- **Unknown.** Status of progress is unknown or information is not available.

Audit team

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Appendix A Excerpts from our 1999 Report, Chapter 27, National Defence—Alternative Service Delivery

Background

The NATO Flying Training in Canada (NFTC) program is a military pilot training program conducted in co-operation with industry for the Canadian Forces and other participating nations. Since it was initiated prior to the implementation of the Alternative Service Delivery program, it is not being managed under that framework.

In addition to developing a cost-effective pilot training program, NFTC is supposed to achieve a number of other benefits:

- creating employment;
- keeping the base at Moose Jaw open;
- demonstrating the capabilities of Canada's aerospace industry; and
- making a significant contribution to NATO.

Officials also informed us that National Defence had insufficient funds to renew its training aircraft fleets. One ways to combat the "rust out" of the existing fleet was to implement a service contract that required annual installment payments.

In 1996, National Defence obtained Cabinet approval of a 20-year, $2.8 billion sole-source contract with Bombardier Inc. for the program. Milit-Air Inc. will purchase the planes, flight simulators and other equipment with the proceeds of a $720 million bond. By way of a separate agreement, Milit-Air Inc. has leased the equipment to Bombardier Inc.

About $1.3 billion of the contract funds will acquire flight simulators and a new fleet of 42 military training aircraft to replace National Defence's existing fleet of Tutor aircraft that, according to departmental studies, could have been refurbished and made to last until the year 2015. The remaining $1.5 billion will be used by Bombardier Inc. to maintain the aircraft and the simulators, manage the base in Moose Jaw, and provide ground school instructors. National Defence will provide the overall management of the NFTC program and the flight instructors. The first flight instructors were to start training in the third quarter of 1999.

The contract was awarded without competition

We found that the decision to award the contract without following the normal bid solicitation process for government contracting was not adequately justified.

The profit mark-up in the NFTC contract is not consistent with current guidelines or supported by adequate analysis of contractor's risks

In the event of a sole-source contract, Public Works and Government Services Canada's profit policy and guidelines are supposed to establish the level of profit awarded to a contractor. Public Works and Government Services Canada officials could not provide us with the detailed calculations and risk assessments they used to arrive at the profit markup included in the contract. According to officials of both departments, the NFTC program will provide the government with valuable benefits through the transfer of significant risks to the contractor over the next 20 years. Although departmental documents show the departments' estimate of contractor risk to be between $360 million and $460 million, they had no calculations to support this. They estimate that the risk exposure to the contractor relates to the following:

- the quantity and adequacy of the aircraft required for the program;
- future increases in aircraft and infrastructure operating costs;
- failure to obtain the expected number of foreign participants; and
- environmental risks.

We expected that the two departments would comprehensively assess the risks being transferred to the contractor and estimate the value to the Crown of that risk transfer. We were unable to establish that this had been done.

Public Works and Government Services Canada informed us that it hired an outside consultant to review the risk elements in this program. We note that the consultant could not perform a comprehensive review of all the risks since, at the time, the agreements had not been finalized. Therefore, in our opinion the review was not sufficient to provide assurance that there is an equitable sharing of risks under the contract.

In response to our audit, National Defence officials prepared a risk summary in late September 1999 that attempted to quantify the value of the risks transferred to the contractor. While this summary clearly identified the major risks, it did not assess their probability of occurrence and their overall financial impact. As a result, it is not possible to establish the correlation between the value of the risks and the profit markup that was negotiated in the NFTC contract.

It should be noted that if the NFTC program expands beyond its current level, the Department is committed to paying for the additional aircraft and equipment that will be required. These costs would be recovered from the additional revenues from foreign participants. According to National Defence officials, if the program were to expand beyond its current capacity there would be significant financial benefits to both the Crown and the contractor, because the fixed costs of the program would be shared among a greater number of participants.

The chosen financing arrangements increase some risks

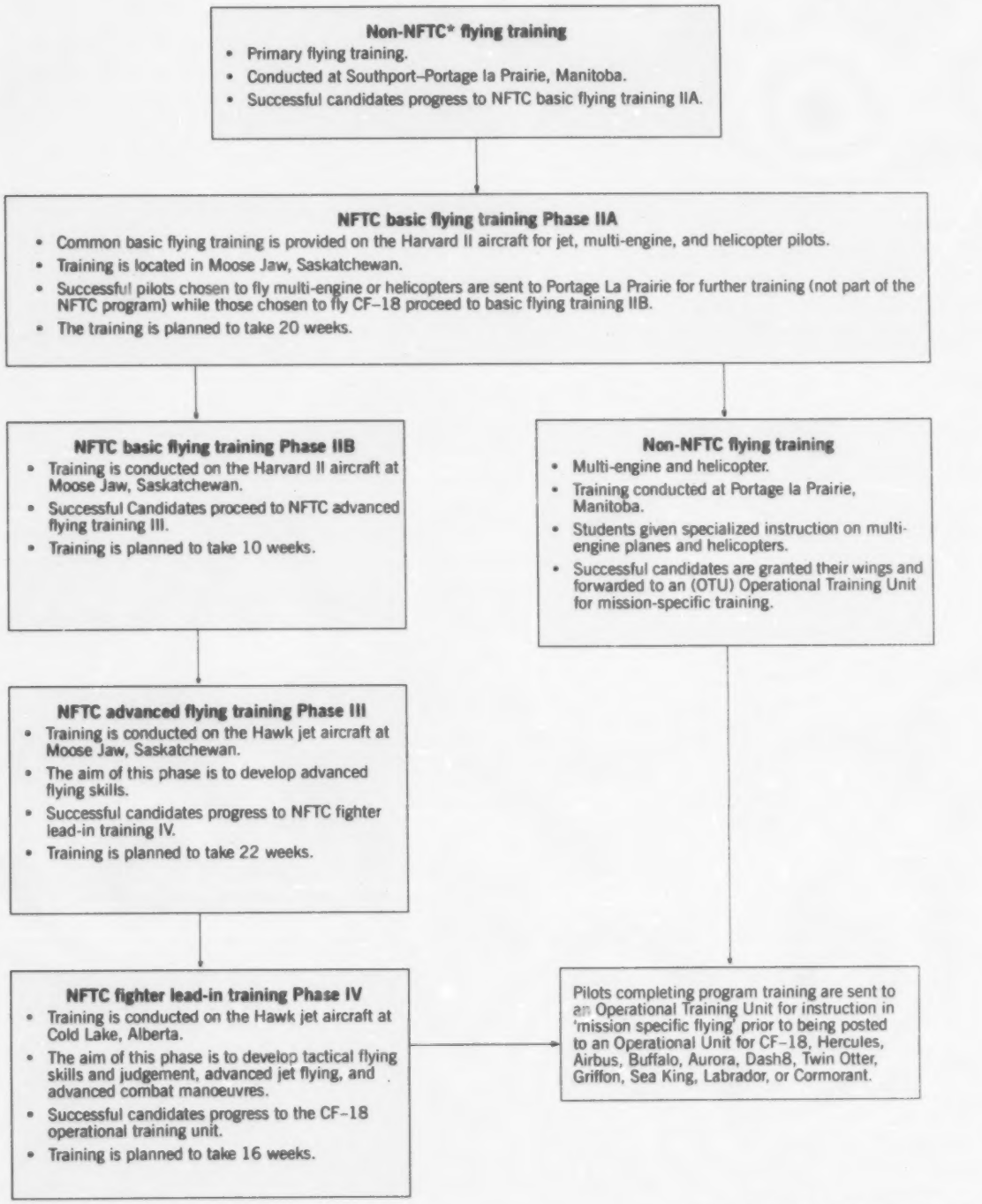
The NFTC program is the first example of "innovative" financing for a major National Defence capital project.

The Department of Finance had suggested in late May 1997 that the Department consider purchasing the equipment directly and supplying it to the contractor as government-supplied equipment. In response, National Defence prepared an analysis of industry financing compared with government financing of the NFTC assets. We found that this analysis was not complete and that it was performed at a point when it was impractical to make any changes to the financing arrangements.

The unique financing arrangements are also causing problems with the acquisition of the Raytheon T6-A aircraft and related technical data. The U.S. Department of State has serious concerns about a private company, Milit-Air Inc., owning military aircraft. It is concerned about Canada's ability to control the transfer of information and the use and resale of aircraft owned by Milit-Air Inc. The two governments have been working on a solution, and it is expected that the Canadian government will be providing the necessary assurances shortly. However, the issue is not yet completely resolved.

The fact that these additional risks are present leads us to believe that a more rigorous assessment of alternatives for acquiring the assets ought to have been prepared, and earlier in the process.

Appendix B National Defence's pilot training process


Non-NFTC* flying training
• Primary flying training.
• Conducted at Southport–Portage la Prairie, Manitoba.
• Successful candidates progress to NFTC basic flying training IIA.
NFTC basic flying training Phase IIA
• Common basic flying training is provided on the Harvard II aircraft for jet, multi-engine, and helicopter pilots.
• Training is located in Moose Jaw, Saskatchewan.
• Successful pilots chosen to fly multi-engine or helicopters are sent to Portage La Prairie for further training (not part of the NFTC program) while those chosen to fly CF–18 proceed to basic flying training IIB.
• The training is planned to take 20 weeks.
NFTC basic flying training Phase IIB
• Training is conducted on the Harvard II aircraft at Moose Jaw, Saskatchewan.
• Successful Candidates proceed to NFTC advanced flying training III.
• Training is planned to take 10 weeks.
Non-NFTC flying training
• Multi-engine and helicopter.
• Training conducted at Portage la Prairie, Manitoba.
• Students given specialized instruction on multi-engine planes and helicopters.
• Successful candidates are granted their wings and forwarded to an (OTU) Operational Training Unit for mission-specific training.
NFTC advanced flying training Phase III
• Training is conducted on the Hawk jet aircraft at Moose Jaw, Saskatchewan.
• The aim of this phase is to develop advanced flying skills.
• Successful candidates progress to NFTC fighter lead-in training IV.
• Training is planned to take 22 weeks.
NFTC fighter lead-in training Phase IV
• Training is conducted on the Hawk jet aircraft at Cold Lake, Alberta.
• The aim of this phase is to develop tactical flying skills and judgement, advanced jet flying, and advanced combat manoeuvres.
• Successful candidates progress to the CF–18 operational training unit.
• Training is planned to take 16 weeks.
Pilots completing program training are sent to an Operational Training Unit for instruction in 'mission specific flying' prior to being posted to an Operational Unit for CF–18, Hercules, Airbus, Buffalo, Aurora, Dash8, Twin Otter, Griffon, Sea King, Labrador, or Cormorant.

*NFTC—NATO Flying Training in Canada

Appendix C NATO Flying Training in Canada program milestones

Year	Milestones
1992	NATO requirement identified for a common NATO fast jet pilot training program.
1992–1994	National Defence begins analyzing and defining future pilot training options.
1994	Bombardier submits unsolicited proposal to National Defence for fast jet pilot training.
December 1994	Bombardier submits a business case and National Defence adds NATO Flying Training in Canada (NFTC) as an option.
May 1995	Canada submits proposal to host the NFTC program to NATO.
January 1996	Bombardier delivers an industry proposal to National Defence. National Defence compares the options and identifies NFTC as the preferred option.
June 1996	National Defence gets approval to enter into a 20 year $2.8 billion sole source contract with Bombardier to provide support to NFTC. Approval was given on the condition that international nations participate as a means of reducing costs for Canada.
	Canadian proposal to NATO nations.
April 1997	NFTC launch and negotiations.
May 1998	Services agreement in support of military pilot training signed between Bombardier and Public Works and Government Services Canada (on behalf of Canada). Moose Jaw and Cold Lake transition begins.
September 1998	Memorandum of understanding (MOU) signed between Canada and Denmark for participation in the program.
July 1999	MOU signed between Canada and the U.K. for participation in the program.
December 1999	Canada makes the first of 40 semi-annual payments of $32 million for use of equipment plus first instalment of firm, variable and cost reimbursable fees.
	Planned start date for Phase II instructor pilot training and course validation delayed due to late delivery of Harvard II aircraft.
February 2000	First four basic flying training Phase IIA courses cancelled.
March 2000	MOU signed between Canada and Italy for participation in the program.
	MOU signed between Canada and Singapore for participation in the program.
June 2000	Basic flying training Phase IIA courses begin.
December 2000	Advanced Phase III flying training courses begin.
March 2002	Fighter lead in Phase IV flying training courses begin.
	MOU signed between Canada and Hungary for participation in the program.

Chapter

5

Industry Canada

Management of the Canada Small Business Financing Program

The audit work reported in this chapter was conducted in accordance with the legislative mandate, policies, and practices of the Office of the Auditor General of Canada. These policies and practices embrace the standards recommended by the Canadian Institute of Chartered Accountants.

Table of Contents

Key Message 1

Introduction 3

Events since our audit of 1997 3
The program today 3
Focus of the follow-up 6

Observations and Recommendations 6

Measuring program performance 6

A performance evaluation framework is in place 7
Data collection on the Program's performance has begun 7
Still a need to define criteria for assessing the Program's success 7

Cost recovery 8

The Department is unlikely to achieve its cost recovery objective 8
Monitoring capacity is improving; forecasting methods need to be enhanced 9

Improving the Program's delivery 10

Tools being developed to monitor compliance with the Act and Regulations 10
The issue of related entities has been clarified 10
The claims-processing procedure is effective 10
The Department has reduced the interest paid to lenders 11

Accountability to Parliament 12

Information provided to Parliament still needs improvement 12

New issue of importance 13

The decrease in the number of loans warrants further study 13

Conclusion 13

About the Follow-Up 15

Industry Canada

Management of the Canada Small Business Financing Program

Assistant Auditor General: Richard Flageole
Responsible Auditors: Richard Gaudreau and Chantal Thibaudeau

Key Message

5.1 Industry Canada has made progress in addressing some of the issues raised in our 1997 Report, as outlined in the table below. We are still concerned about the ability of the Department to achieve its cost recovery objective for this Program. At 31 March 2001, losses on loans guaranteed between 1995 and 1999 amounted to $155 million, and we estimate that they will reach at least $200 million. There are also indications that disbursements on claims will exceed revenues for loans guaranteed after 1999. Industry Canada must develop a better model to forecast the financial performance of the Program. Parliament must also be informed on a timely basis of any anticipated losses.

ORIGINAL ISSUES	PROGRESS	RATING*
Measuring program performance		
5.2 The Department should clearly define the expected results of the Program and obtain relevant information on the Program's results.	The Department developed a program evaluation framework in 1998 and used it to guide its data collection activities. However, it still needs to define criteria for assessing the Program's success, including a target range for incrementality.	LIMITED PROGRESS
5.3 The Department should ensure that the *Small Business Loans Act* eligibility requirements and conditions lead to the results expected for the Program.	Program eligibility criteria and conditions were examined as part of the review of the *Small Business Loans Act* in 1998 and changes were made to Program conditions. The impact of these changes on the Program's expected results, including cost recovery, will need to be carefully assessed.	LIMITED PROGRESS
Cost recovery		
5.4 We expressed uncertainty about whether full cost recovery would be achieved. We concluded that the dual objectives of increasing access to financing while recovering the costs of the Program called for careful analysis. The Department should carefully monitor the performance of the loans portfolio and improve systems and practices for forecasting the future performance of the Program.	The Department considers that it will not meet its cost recovery objective for loans guaranteed between 1995 and 1999. We estimate that disbursements on claims for that period will exceed revenues by at least $200 million. There are also indications that the Department may not meet its cost recovery objective for loans guaranteed after 1999. The Department now has good information on portfolio risks. This provides a basis for monitoring the financial performance of the Program. The Department has yet to adjust its claims forecasting model.	LIMITED PROGRESS

*Possible ratings are: completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Follow-Up for an explanation of the ratings.)

ORIGINAL ISSUES	PROGRESS	RATING*
Improving the Program's delivery		
5.5 The Department should ensure that lenders have exercised due care in making loans and have complied with the Small Business Loans Act and Regulations.	Legislation was amended to reinforce the principle of due diligence by financial institutions and to give the Minister authority to conduct compliance audits. The Department is working on an audit strategy, and it plans to start conducting audits in the fall of 2002.	
5.6 The Department should assess the need to limit access to loans by related entities to the maximum amount allowed and, if the need exists, seek amendment to the *Small Business Loans Act*.	The *Canada Small Business Financing Act* clarifies this matter, and the Department now requires the borrower to declare that it has not exceeded the maximum loan limit.	
5.7 The Department should take the necessary measures to reduce the amount of interest paid on claims made by lending institutions.	The Department has introduced two main measures: the interim payment of a claim before the borrower's personal collateral has been collected and the non-payment of interest beyond 24 months following the date of the loan default.	
Accountability to Parliament		
5.8 The Department should ensure that parliamentarians are provided with the necessary information to assess the extent to which the Program is managed efficiently and is achieving its objectives.	The Department has improved information on cost recovery but it provides limited information on the expected financial performance of the Program and efficiency of operations.	
5.9 The Department should report information on job creation that reflects actual results attributable to the Program.	The Department has clarified the meaning and indicated some limitations of the information provided on the number of jobs to be created by the Program.	

NEW ISSUE
5.10 Since 1998 there has been a significant decrease in the number of loans made through the Program. The Department should continue its efforts to determine the reasons for the drop and how they affect the rationale for the Program and its parameters. It should also investigate the concerns that financial institutions have expressed about the administrative requirements of the Program.

*Possible ratings are: completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Follow-Up for an explanation of the ratings.)

Industry Canada has responded. The Department has generally agreed with our conclusions. Its response, presented at the end of the chapter, elaborates on the action it intends to take to address both the issues we raise in the report and our recommendation.

F3

Introduction

5.11 In Chapter 29 of our December 1997 Report, we reported on Industry Canada's management of the Small Business Loans Program, governed at the time by the *Small Business Loans Act*.

5.12 In that chapter, we said that Industry Canada needed to define more clearly the results it expected the Program to achieve and better measure its performance toward achieving them. We questioned whether the Department could meet its objective of full cost recovery, given the fee structure and loss-sharing ratio then in effect. We emphasized the need to carefully analyze the dual objective of making loans more accessible while recovering the costs of the Program. We stressed that Industry Canada needed tighter controls to ensure that lenders exercised due diligence in granting loans. We said it should take appropriate steps to reduce the amounts it was paying to financial institutions in interest on their claims. Finally, we noted that Parliament needed better performance information on the Program.

Events since our audit of 1997

5.13 In 1998, the Standing Committee on Public Accounts held hearings on our report and made recommendations similar to ours in its own report to Parliament. The House of Commons Standing Committee on Industry and the Standing Senate Committee on Banking, Trade and Commerce each held public hearings on the Program that same year to better understand the financing needs of Canadian small and medium-sized enterprises (SMEs).

5.14 These reviews led to the *Canada Small Business Financing Act*, which came into force on 1 April 1999 and replaced the Small Business Loans Program with the Canada Small Business Financing Program. The new legislation maintains the fundamental objective of the Program and its key parameters (percentage guaranteed by the government, type and size of business, and registration and administrative fees). It also provides for a mandatory comprehensive review of the Program every five years; the next review report must be tabled in Parliament in 2004–05. It reinforces the principle by which financial institutions must show due diligence in managing loans registered under the Program, and it gives the Minister authority to conduct on-site audits to verify their compliance. Exhibit 5.1 provides additional information on the history of the Program. Exhibit 5.2 provides data on the value of loans guaranteed over the past 10 years.

The program today

5.15 The purpose of the Canada Small Business Financing Program is to increase the availability of financing to establish, expand, modernize, and improve small business enterprises. Industry Canada is committed to compensate financial institutions for 85 percent of their eligible losses on loans they have made under the Program. Any business (except for religious, not-for-profit, and farming organizations) with gross annual revenues below $5 million is eligible for financing to a maximum of $250,000. The maximum

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repayment period for a loan under the Program is 10 years. A lender is allowed to obtain a personal or a corporate guarantee from the borrower, although a personal guarantee cannot exceed 25 percent of the loan amount. Businesses can use the loans to finance real property and buildings, leasehold improvements, or equipment. Exhibits 5.3 and 5.4 show loans guaranteed under the Program in 2000–01, by industry sector and by area of use.

Exhibit 5.1 Program history

From 1961 until 1993, the Small Business Loans Program was stable and relatively modest. Between 1990 and 1993, the average annual value of loans guaranteed under the Program was $438 million, and the Department paid financial institutions an average of $41 million a year in claims and interest for losses on loans they had made under the Program.

In 1993, a number of changes to the *Small Business Loans Act* broadened the eligibility criteria for the Program by raising from $2 million to $5 million the maximum annual revenue of a business defined as "small business." Also raised were the maximum loan amount, the portion of a loan that the Department would guarantee, the percentage of a project's total funding allowable under the Program, and the registration fees.

The result was more loans, for higher amounts. The annual value of loans guaranteed under the Program rose from $502 million in 1992–93 to $2.5 billion in 1993–94 and $4.4 billion in 1994–95. This unprecedented increase created concern about the financial consequences for the government: very likely, it would see a corresponding increase in claims by financial institutions for losses. In fact, by 31 March 2002, loans guaranteed between 1 April 1993 and 31 March 1995 had generated $527 million in claims, which the government paid. We estimate that the actual loss suffered by the government was $388 million after taking into account the registration fees it had received for the same loans.

That concern led Parliament in 1995 to tighten certain of the 1993 amendments to the Act that had broadened eligibility for the Program, and the Program's major parameters have remained the same since then.

Exhibit 5.2 Annual value of loans guaranteed from 1990–91 to 2000–01

Source: Industry Canada

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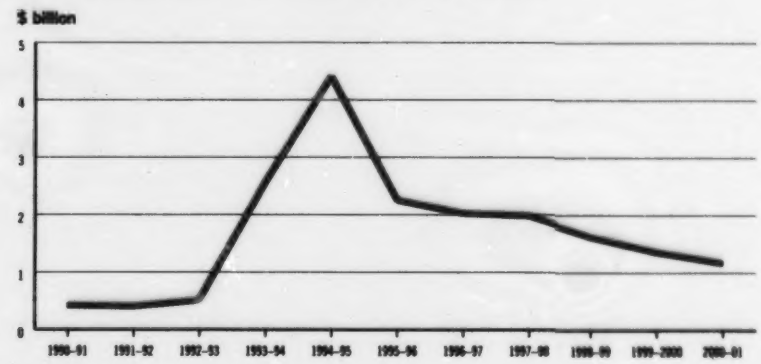
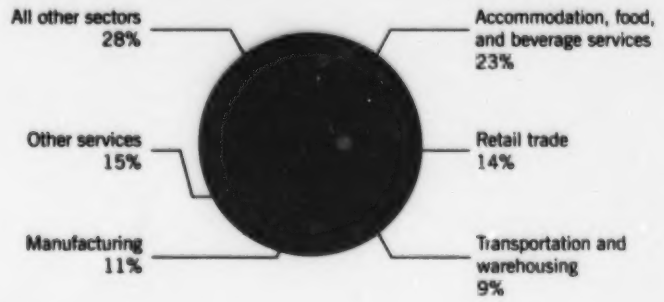


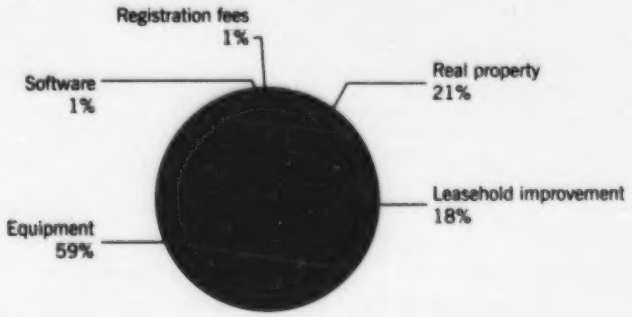
Source: Industry Canada

Exhibit 5.3 Loans guaranteed though the Program to industry sectors in 2000–01



Source: Industry Canada

Exhibit 5.4 Areas of use of loans guaranteed through the Program in 2000–01



Source: Industry Canada

5.16 Industry Canada delivers the Program in partnership with financial institutions. A small business applies to an institution for financing; the institution assesses the application and assumes responsibility for deciding whether or not to grant the loan. If it does, it makes the loan directly to the applicant. It is responsible for all aspects of credit management.

5.17 When a financial institution determines that a loan meets the conditions of the Program, it submits it to the Department for registration as a guaranteed loan with a 2 percent registration fee it has collected from the borrower. An annual administration fee of 1.25 percent based on the average monthly loan balance is also charged and turned over to the Department. Lenders cannot charge more than 3 percent above the prime lending rate on floating-rate loans or more than 3 percent above the residential mortgage rate on fixed-rate loans; the interest charges include the 1.25 percent administration fee. If the borrower defaults, the financial institution must collect the security pledged against the loan before it can submit a claim to Industry Canada.

5.18 The Small Business Loans Administration Directorate of the Department's Operations Sector administers the Program under the provisions of the Act and its Regulations. The Directorate has an annual operating budget of $3 million and a staff of 30 people, most of them assigned to claims processing. The Small Business Policy Branch, part of the Department's Policy Sector, provides strategic direction for the financing of small businesses.

5.19 In 2000–01, more than 14,000 loans with a value of about $1.2 billion were registered under the Program. The average amount of each loan was about $80,000. In the same period, the Department paid out about $171 million in claims for loans guaranteed under the previous and the new legislation.

Focus of the follow-up

5.20 Our follow-up looked at Industry Canada's management of the Canada Small Business Financing Program and its administration of the *Canada Small Business Financing Act* and the *Small Business Loans Act*, which guide the Program. The purpose of our follow-up was to assess Industry Canada's progress in addressing the issues raised in our 1997 audit and to determine whether the Department now has in place the systems and practices to manage the Program efficiently, cost-effectively, and in accordance with legislative authority. Our follow-up scope and criteria are set out in About the Follow-Up at the end of the chapter.

Observations and Recommendations

Measuring program performance

5.21 According to Industry Canada, investment stimulates economic growth and innovation and helps ensure sustainable development; one of the Department's strategic objectives is to promote investment in Canada. It views limited access to capital as a barrier to investment by small and medium-sized enterprises (SMEs).

5.22 The intent of the Canada Small Business Financing Program is to encourage financial institutions to give small businesses greater access to financing for their creation, expansion, modernization, and improvement.

5.23 Our 1997 report recommended that Industry Canada clearly define the results it expected the Program to deliver and obtain relevant information on the results it achieved. We also stressed the need to ensure that the Program's eligibility requirements and conditions foster the achievement of the desired results. After examining our report in 1998, the Standing Committee on Public Accounts recommended that the government clearly define its expectations for the Program's performance, set clear targets for incrementality, establish appropriate indicators of performance, and ensure that the Program met the financing needs of small businesses.

A performance evaluation framework is in place

5.24 In 1998, the Department developed a performance evaluation framework for the Program. This evaluation framework, developed as part of the review of the *Small Business Loans Act*, identifies evaluation issues, performance indicators, data collection requirements, and options for the future evaluation of the Program. Issues to be evaluated are the relevance of increased access to financing for small business and the need for federal involvement; the level of incrementality achieved by the Program; progress toward cost recovery; reliability of claims forecasting; the Program's impact on job creation, maintenance, and displacement; awareness of the Program; and the performance of borrowers.

Data collection on the Program's performance has begun

5.25 In 1998 the Task Force on the Future of the Canadian Financial Services Sector (MacKay Task Force) found that the development of a public policy on the financing of small and medium enterprises (SMEs) was hindered by a lack of data. It recommended that the government make a concerted effort to improve the quality and quantity of information on SME financing. In response, Industry Canada, Statistics Canada, and the Department of Finance Canada launched the SME Financing Data Initiative. The Department has carried out six studies under the initiative to better understand the issue of SME financing and plans to continue studying it over the next few years. The studies provide valuable information on the relevance of the program.

5.26 To measure the effectiveness of the Program, the Department has conducted a survey of businesses to assess the impact on both the job creation and the performance of businesses that had received loans. It also surveyed SMEs to better understand their experience in looking for and obtaining financing and to determine how much they knew about the Program

Still a need to define criteria for assessing the Program's success

5.27 In 1997, we indicated that it was important for the Department to define the level of incrementality it expected the Program to achieve, and adjust the parameters of the Program accordingly; the Standing Committee on Public Accounts made the same recommendations in 1998. (The level of incrementality is the extent to which businesses obtain financing through the Program that otherwise would not be available to them or would be available on less favourable terms.) The evaluation framework developed by the Department still does not specify the rate of incrementality that would represent success. The latest related study by the Department, in 1996, found that 54 percent of the loans guaranteed through the Program could not have been obtained without it.

5.28 The Department is presently reviewing its 1998 evaluation framework to take into account Treasury Board Secretariat's new policy on measurement of results. The review is intended to lead to a new results-based management and accountability framework. According to the Department, the new

framework will be in place by the fall of 2002 and will guide the evaluation of the Program in 2004.

Cost recovery

The Department is unlikely to achieve its cost recovery objective

5.29 Under the cost recovery policy adopted in 1995, the Department aims to balance the Program's costs (claims and interest it pays to financial institutions) with its revenues (registration and administration fees). The Program costs in this equation exclude the Department's salary and operating expenses for the Program.

5.30 In 1997, we questioned whether the Department could achieve cost recovery given the fee structure and loss-sharing ratio then in effect. In this follow-up, we reviewed the Department's data and reports on the Program's financial results for loans guaranteed between April 1995 and March 1999 under the *Small Business Loans Act* and between April 1999 and March 2002 under the *Canada Small Business Financing Act*.

5.31 **Financial performance—1995 to 1999.** In its 2000–01 annual report on the Program, the Department stated that it does not expect to meet its cost recovery goal for loans guaranteed between 1 April 1995 and 31 March 1999. It considers that cost recovery can be achieved only if paid claims do not exceed 6.5 percent of the value of guaranteed loans, and it has indicated that claims to be paid on loans guaranteed during that period will amount to 9 percent of the total value of the loans. At the end of March 2001, this represented losses of $155.8 million. We estimate that these losses will exceed $200 million over the life of the loans.

5.32 **Financial performance—1999 to 2002.** When it reviewed the Program in 1998, the Department considered that no changes were needed in the Program's key parameters (percentage guaranteed by the government, size and type of business, and registration and administrative fees structure). It did recommend changes, however, that it believed would allow for a better balance between revenues and expenditures. Among the changes were an obligation for lenders to exercise the same diligence as they do with their conventional loans; the possibility for the Department to conduct on-site audits of lenders' files; new provisions to prevent loan splitting; interim payment of claims to reduce interest costs; and a broadening of the rules on security pledged against loans made under the Program. These recommended changes were incorporated in the revised legislation.

5.33 A study conducted for the Department in November 2001 on payment defaults and claims for loans registered from 1995 to 1998 identified the sectors with the highest loss rates. The rate for the accommodation, food, and beverage industry was 11.6 percent, for leasehold improvements 9.7 percent, and for franchising 9.6 percent. The study also showed that loans of $100,000 or more also carried a higher loss rate, at 14.4 percent.

5.34 Our review of the distribution of loans guaranteed since 1999 shows that with one exception, the same sectors represent an increasing share of the portfolio, suggesting that the overall level of risk is increasing as well:

- The proportion of total loan value that went to the accommodation, food, and beverage industry increased from 13.1 percent to 22.7 percent.
- The proportion of total loan value that went to the leasehold improvements sector increased from 14.2 percent to 17.5 percent.
- Loans of $100,000 or more increased from 21.6 percent to 27.8 percent of the total number of loans.

The exception is the franchising sector, whose share of the total loan value has decreased from 12 percent to 11 percent over the same period.

5.35 Our analysis of claims paid to date on loans guaranteed in 1999–2000 suggests that there is no downward trend in the loss rate. Claims paid on loans registered in 1999–2000 amount to 3 percent of the value of the loans. This three-year loss rate is similar to three-year loss rates observed since 1995–96. We believe it is unlikely that the rate of claims paid will decline enough to allow for cost recovery. The Department is still faced with the difficult objective of achieving cost recovery while maintaining an acceptable rate of incrementality.

Monitoring capacity is improving; forecasting methods need to be enhanced

5.36 In 1997, we recommended that to improve its chances of meeting its cost recovery objective, Industry Canada monitor changes in the performance of its loan portfolio more closely and consider any new economic factors that could prevent cost recovery. We also recommended that it enhance the systems and practices it used in forecasting how well the Program would perform. We believed that the Department needed to analyze its loan guarantee portfolio regularly for risks inherent in characteristics such as industry sector, type of loan, region, and age of the business.

5.37 The November 2001 study of payment defaults and claims for loans registered from 1995 to 1998 allowed the Department to understand better the factors contributing to increased risk in its loan portfolio and to determine the actual financial performance of these loans. The Department had last carried out such a study in March 1997. This provides a basis for future regular monitoring of the Program's financial performance. Also, the Department's annual report on the Program now includes the level of claims paid, by industry sector; and the net cost of the program, by year in which the loans were made.

5.38 The Department has had a model to forecast the financial performance of the loan portfolio since 1994; responding to our 1997 recommendation, it said it would revise the model. In this follow-up, we observed that the Department has not made the changes that would allow its forecasting model to better reflect factors that could impact the level of claims. We still believe that a better forecasting model would give the Department an effective tool to ensure prudent management of public funds and inform Parliament of anticipated shortfalls.

Improving the Program's delivery

Tools being developed to monitor compliance with the Act and Regulations

5.39 In 1997 we examined files of financial institutions on loans made under the *Small Business Loans Act*, and we observed that they did not always contain evidence that the Program rules had been followed. We stressed that the Department needed mechanisms to ensure that financial institutions were exercising due care when they issued loans.

5.40 The changes made to the legislation in 1999 reinforce the principle that financial institutions must exercise due diligence in making and administering loans under the Program. The Regulations now require that lenders apply the same procedures to these loans as they would to their conventional loans.

5.41 The new Act also gives the Minister the authority to audit for compliance with the Act and Regulations, including the due diligence and documentation requirements. The Department is finalizing an audit strategy for on-site review of practices used by financial institutions. It has not yet started conducting audits; it has informed us that it will begin in the fall of 2002.

The issue of related entities has been clarified

5.42 We noted in 1997 a number of separate corporations with substantially common ownership had obtained among them more than $250,000 in loans to operate the same business. We said that situations like this increased credit risk and could cause higher losses in the loan portfolio. We also pointed out that the Act contained no provisions to prevent a group of related entities from obtaining loans that totalled more than the maximum allowed by the Program. We recommended that Industry Canada tighten its controls and examine the possibility of limiting to $250,000 the maximum guaranteed loans to related entities.

5.43 The 1999 Act and Regulations define related borrowers more precisely and limit to $250,000 the financing to which related entities can have access. Furthermore, the Department now asks borrowers to declare on the loan registration form that they are not exceeding the allowable limit on financing. Also, the action plan for compliance audits of financial institutions includes audit procedures aimed at loans between persons with a non-arm's-length relationship.

The claims-processing procedure is effective

5.44 The Department processed 3,748 claims in 2001–02. The average time it took to process a claim was 35 days from the receipt of all required information; over the last five years, this has fluctuated between 28 and 45 days. These data reflect claims related to loans guaranteed under both the *Small Business Loans Act* and the *Canada Small Business Financing Act*.

5.45 The Small Business Loans Administration Directorate uses a number of tools to ensure that staff assigned to claims processing follow uniform practices. It developed a procedures guide; and it documented its policies on the interpretation of the Act and Regulations and its decisions on new issues

in claims processing. It has also adopted an appeal mechanism to review decisions that lenders dispute. We noted that staff assigned to claims processing have the needed experience and expertise to process claims.

5.46 The claims-processing procedure includes a number of steps; the most important is analyzing the information that the financial institution provided to justify the amount of its claim. In this step, the Department verifies whether the loan met the conditions of the Program (size of the business, activity, type of asset financed, interest rate, and terms of the loan) and whether the financial institution collected the collateral that secured the loan before submitting its claim.

5.47 Our examination of a sample of claims processed in 2001–02 showed that the Department uses a valid procedure to ensure that claims are properly justified.

The Department has reduced the interest paid to lenders

5.48 A lender has up to three years to claim its losses on a defaulted loan. During that time, it must take all possible measures to collect on the loan before submitting a claim. The claim is to include the eligible proportion of the unpaid principal as well as interest on that amount. The $144 million in claims paid in 2001–02 included interest of $24 million and, on average, lenders submitted their claims 19 months after the borrower had defaulted on the loan. These data reflect claims related to loans made under both the *Small Business Loans Act* and the *Canada Small Business Financing Act*.

5.49 In 1997 we recommended that the Department take appropriate steps to reduce the total amount it was paying in interest on claims submitted by financial institutions.

5.50 The Regulations to the 1999 Act introduced a provision allowing a lender to submit an interim claim before having collected a borrower's personal collateral, but after collecting on all other guarantees. In 2001–02, interim claims represented 23 percent of settled claims.

5.51 The Regulations to the 1999 Act also shortened the period for which the government will pay interest to the lender. While lenders still have three years after a default to submit their claims, the Department no longer pays interest to the lender on that whole period. As it did before 1999, it pays for the first year a rate of interest equal to the rate at which the loan was issued, and for the second year it pays half that rate. As of 1999, however, it pays no interest for the third year. We estimate that in 2001–02 this measure contributed to a reduction of $800,000 in interest paid.

5.52 Whether financial institutions can collect on loan security and submit their claims sooner depends on general economic trends as well as conditions in the local real estate and property trade-in markets. The realization of secured assets takes time, but it is essential; in 2001–02 the net amount realized in relation to claims settled in that year was $46 million. Current rules governing interest payments aim to strike a balance between the

amount of interest paid and the due diligence exercised by financial institutions in realizing secured assets.

Accountability to Parliament

Information provided to Parliament still needs improvement

5.53 We noted in 1997 that Parliament was receiving mainly operational information on the Program and not the kind of information needed to assess its performance. The Department was providing no information on the extent to which it had achieved its cost recovery and incrementality objectives. We also questioned the reliability of its information on the job creation impact of the Program.

5.54 In this follow-up, we reviewed the Department's annual reports on the Program for the last five years. We noted that they now include better information on the achievement of the cost recovery objective. The Department has also clarified the meaning of the data it provides on the number of jobs created by the Program and has indicated some of the data limitations. We also saw more information on Program activities.

5.55 **Cost recovery.** The annual report presents financial information on revenues and on claims expenditures. However, it provides no information on the Program's expected financial performance. For example, the Department states that it will not achieve its cost recovery goal for loans guaranteed between 1995 and 1999. It gives no specific indication of the possibility of recovering its costs for loans guaranteed from 1999 on, because it believes it does not have enough data on claims for this period.

5.56 **Job creation.** The Department now provides information on the expected number of jobs to be created, by industry sector and by business size. The information is presented with the caveat that it comes from borrowers' projections of the number of jobs they expect to create. In 2002, Industry Canada commissioned a survey of firms that had obtained loans under the Program between January and July 2000. It asked them to confirm how many jobs they had created; most confirmed their initial estimates. The Department plans to repeat the survey at regular intervals.

5.57 The Department still does not indicate clearly all the limitations of its data on job creation. The information does not account explicitly for potential job displacement due to the creation of a new business or the modernization of an existing business, or for the fact that a number of businesses that receive funding under the Program also obtain funding from other sources.

5.58 **Efficiency.** The annual report contains little information on the administrative efficiency of the Program's operations. For example, it does not provide data on the cost and the length of time required to process a claim, the number of claims denied, and the number of appeals on rejected claims and their results.

5.59 The Department has informed us that it remains committed to improving the information it provides to Parliament in its annual report, particularly on the expected financial performance of the Program.

New issue of importance

The decrease in the number of loans warrants further study

5.60 The number of loans made through the Program has dropped significantly since 1998. To understand the reasons, the Department commissioned a study in the form of a survey of financial institutions; the study report was released in January 2002. The financial institutions see as the major reason for the decline the amount of administrative work involved in processing the loans and the Department's growing tendency to deny claims. During our follow-up, we met with representatives of major financial institutions to obtain their views on the administration of the Program and to understand how they deliver it. They reiterated to us their concern about the administrative burden of the Program.

5.61 Other reasons mentioned in the study were the lack of profit on these loans, a greater choice of financing options for borrowers, the possibilities for borrowers to get loans with better conditions, an increase in financing through internal means, and competition among lending institutions. The Department has not yet validated the conclusions of this study.

5.62 The study provided the Department with interesting leads to explain the decline in loans under the Program. However, its scope and methodological limitations affected the depth of analysis and the reliability of conclusions.

5.63 **Recommendation.** Industry Canada should

- thoroughly examine the reasons for the decline in the number of loans and assess their impact on the rationale and the design of the Program, and
- investigate the concerns of financial institutions about the administrative requirements of the Program.

Industry Canada's response. The Department has responded to the chapter overall; its response follows the Conclusion.

Conclusion

5.64 Industry Canada spent considerable time and effort in 1998 to review the *Small Business Loans Act*. The Act was subsequently replaced in 1999 by the *Canada Small Business Financing Act*. Some of the issues we had raised in our 1997 Report were addressed directly in the new Act with the inclusion of the due diligence principle in the legislation, clarification of the concept of related entities, and inclusion of measures to reduce interest paid on claims submitted by lenders.

5.65 The Department has taken measures to improve the management of the Program. It developed an evaluation framework and has begun to collect data to measure the Program's performance. It has yet to define criteria for assessing the Program's success. We are still concerned about the Department's ability to achieve the cost recovery objective of the Program. It has improved its capacity to monitor the Program's financial performance but has yet to enhance its claims forecasting model.

5.66 The Department has also made progress in its accountability to Parliament. It now provides information on the Program's revenues and expenditures but not on its expected financial performance. The Department provides little information on the limitations of its job creation data and the efficiency of its operations.

5.67 The decline in the number of loans under the Program is a new issue the Department needs to monitor. It needs to understand the reasons for this drop and the impact on the rationale and design of the Program.

Industry Canada's response and comments. As recognized by the Auditor General in the chapter's conclusion, Industry Canada has made considerable progress with respect to issues raised in the Auditor General's 1997 Report. In addition, the Department expects that further progress will be achieved in the fall of 2002 with the implementation of its audit plan and a new results-based management and accountability framework, which will further define performance indicators for the Program.

Industry Canada acknowledges that continuous monitoring of the Program is essential to achieving its objectives of incrementality and cost recovery. Concerning cost recovery, Industry Canada forecast in its 2000–01 Annual Report that over the life of the loans made in 1995 to 1999, disbursements on claims will exceed revenues received. The development of an improved forecasting model is a high priority and has been since the introduction of the new Act. Having collected program data for three years, consistent with the new Act, Industry Canada is now positioned to adjust its forecasting model. In addition, Industry Canada will be reviewing these data to determine whether to recommend any changes to the Program to meet the cost recovery objective.

Finally, Industry Canada will, as recommended, continue to carefully monitor changes in the level of use of the Program. The administrative requirements will also be monitored in order to achieve the appropriate balance between the informational and regulatory requirements necessary to meet our performance measurement and other commitments on the one hand, and the burden on lenders and borrowers in responding to these conditions on the other.

About the Follow-Up

Objective

The overall objective of the follow-up audit was to assess the progress made by Industry Canada in addressing the issues raised in our December 1997 Report. We wanted to determine whether the Department now has the systems and practices in its Program to manage it efficiently, cost-effectively, and in compliance with legislative authorities.

Scope

The follow-up covered Industry Canada's management of the Canada Small Business Financing Program and its administration of the *Small Business Loans Act* and *Canada Small Business Financing Act*, which govern the Program. (The follow-up excluded the capital leasing pilot project launched by the Department in April 2002 to make capital leasing more accessible to SMEs.) We examined the responsibilities and activities of Industry Canada, in particular the Small Business Loans Administration directorate and the Small Business Policy Branch, and those of lenders.

Criteria

Our examination was based on the following criteria:

- The objectives and the expected results of the program related to small business loan guarantees should be clearly stated.
- The Department should have management practices and controls that would ensure that small business loan guarantees are processed efficiently and cost-effectively, that the risks of the program are minimized, and that the objectives of the program are achieved.
- Parliament should be provided with relevant, reliable, and understandable information on the economy, efficiency, and effectiveness of the program.

Approach

We interviewed Industry Canada employees and representatives of financial institutions. We reviewed the studies and reports produced by and for Industry Canada and examined the Department's systems and practices. We also conducted analyses based on the Department's data.

Ratings

We assessed the action of departments/agencies against our original audit recommendations (see Key Message at the beginning of the Chapter). We used the following ratings:

- **Completed.** Corrective action has been fully implemented.
- **Satisfactory progress.** Progress is being made at a satisfactory pace.
- **Limited progress.** Some progress is being made, but the pace or scope is not satisfactory.
- **No progress.** No evidence of progress although the department or agency accepted the recommendation from the original audit.
- **Rejected.** The department or agency did not accept the recommendation from the original audit.
- **Unknown.** Status of progress is unknown or information is not available.

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